ABSTRACT The literature on research ethics tends to overlook the influence of the specific subject matter on the ethical dilemmas that emerge during the research process itself. In this article, the specific subject matter is complementary and alternative medicine (CAM). The article discusses the ethical dilemmas that derive from controversies about research within this highly politicized field, in which scientific knowledge is a potential object of misuse. The article shows that research ethics is no longer a matter of internalizing professional codes of conduct. Rather, it is embedded in the totality of scholarly practice. Ethically aware practice depends to a considerable extent on the qualities and skills of the researcher. The particular skills needed are discernment, imagination, partiality and personal authenticity.

KEYWORDS: CAM, collaborative research, controversy, research ethics, scholarly practice, science and politics, sociology, Sociology of Scientific Knowledge (SSK)

This article aims to explore the way in which the particular subject matter of a research project influences the ethical situations that occur during qualitative inquiry. In so doing, it focuses on how qualitative researchers are inevitably involved in a de facto partisan relationship with ‘the underdog’, meaning those with fewer scientifically or socially endorsed resources. In this article, the particular subject matter in question concerns the field of complementary and alternative medicine (CAM). Here, the position of ‘the underdog’ is occupied by CAM practitioners, in so far as CAM is not officially recognized as a legitimate means of treatment by the public authorities in Denmark, my country of origin. The essential point about the underdog is that s/he suffers, and that her/his suffering is visible. This is also what may make her/him particularly worthy of sympathy (Gouldner, 1968). Although I do not consider alternative practitioners to be deviants such as, for instance, prostitutes and drug addicts (cf. Becker, 1963), they are nevertheless outcasts in the sense that they operate outside the purview of the Danish National Health Board. They are thus officially outsiders (cf. Becker, 1963) and their suffering is visible in
the sense that communication with them and their clients appears to be permeated by a discourse of accreditation and recognition.

The ethical issues discussed in this article emerged during a collaborative research project involving 19 CAM practitioners and four social science researchers, including myself. Our research examines the various dimensions of clients’ bodily experiences with acupuncture, reflexology and mindfulness\(^2\) (see also Baarts and Pedersen, 2009), all of which are relatively prevalent in Denmark. It focuses on the positive benefits described by clients and on the bodily experiences and explorations that they reported during a course of treatment.

During the research, controversies concerning the potential use (and misuse) of scientific knowledge emerged. I will discuss the ethical dilemmas that arose from these controversies and argue that ethics resides in the very subject matter under consideration. I will then go on to elaborate a ‘new ethics’ by identifying those qualities that are embedded in what I term conscious ethical practice.

The article is organized into four parts. The first part concerns the particular subject matter in question, namely CAM in Denmark, and looks at how the non-inclusion of CAM in the health care system produces a discourse of recognition and legitimacy on the part of the collaborators, which had a marked effect on the nature of their participation and interest in the research. Next, I turn my attention to a particular controversy that emerged during this research; in particular, I discuss the implications for academic freedom and independence of engaging in collaborative relationships, and argue that collaborative research relations \textit{per se} are political. In the third part I focus on conceptions and convictions, and in particular on how the discourse of accreditation influences the CAM collaborators’ conceptions of the research agenda, while at the same time challenging the researcher’s preconceptions concerning the subject matter. Finally, I argue for a ‘new ethics’ and elaborate upon the qualities embedded in the conscious ethical practice that I advocate.

Before embarking, however, I will start by discussing the recent literature on research ethics and present my own view of ethics as embedded in the totality of scholarly practice.

\textit{Ethics}

This article embraces the new and ongoing discussion of ethics as embedded in the totality of scholarly practice (Fluehr-Lobban, 2003; Meskell and Pels, 2005; Strathern, 2000): from the initial process of framing the case, to selecting the object of analysis and defining the research questions, to considering how to investigate the object of study, and finally to reflecting on how one’s writings relate to the normative order of the research field. Even after the scholarly text has been published, ethical considerations continue to impose decisions upon us; we need to consider, for instance, how the knowledge arising from the research may be used or misused in commercial or political life. From this perspective, ethics can be seen as a set of interrelated concerns.
(Putnam, 2004: 22) that pertain to a comprehensive way of reasoning about the world. These concerns may relate to tolerance, pluralism, conviction, empathy, respect or sympathy. Thus a re-thinking of ethics can be seen in the literature, which has moved away from the canonical prescriptions by addressing several important issues: whether, for example, there are ethical limits to the expert’s right to information (and if so how to define them), and whether people have the right to remain ‘free of science’ (Meskell and Pels, 2005: 4–5). Scholars working with this approach suggest that a new configuration of ‘home’ and ‘field’ has arisen under the influence of globalization, changing regimes of intellectual property and changing responsibilities towards the people about whom we conduct research. While this new configuration poses questions as to what we are to study, and when, where and how our role as experts ceases to be relevant to what we do, it tends to overlook the influence of the specific subject matter on ethical dilemmas embedded in the totality of scholarly practice. On the basis of my own research on CAM, I will argue that the type of subject matter determines the nature of the ethically sensitive situations that occur during the research process and the kinds of ethical decisions taken by the researcher.

While there appears to be a new tendency in the literature on research ethics toward critical discussions of the regulatory decisions made by IRBs, the majority of journal articles on the topic still seem to focus on the researcher’s struggle to meet ethical obligations relating to e.g. informed consent, privacy, harm and confidentiality, and on the complexity of putting such standards into practice (Goodwin et al., 2003; Gregory, 2003; Guillemin and Gillam, 2004; Liberman, 1999; Marzano, 2007; Punch, 1998). These standards are enshrined in the ethical guidelines and codes of conduct set out by the professions. Such procedural regulation is both necessary and beneficial; it is of course essential that research participants be treated respectfully and with dignity, and that confidentiality of data be maintained. Nevertheless, some of the ethical dilemmas arising from the social processes that we participate in through our research cannot be dealt with by following procedures such as professional codes of conduct, for the depth of ethical being cannot be encapsulated solely in the control exercised by such codes. I will argue that ethical practice is closely linked to the moral life of the particular researcher.

The recent literature tends to treat ethics as primarily a social phenomenon. Whereas ‘ethics in practice’ (Guillemin and Gillam, 2004) relates to the day-to-day ethical issues that arise in doing research and embraces the ‘ethically important moments’ (2004) that emerge in the relationship between the researcher and the researched, ‘relational ethics’ (Ellis, 2007) suggests an epistemological shift from a knower-known relationship to a relationship between ‘two knowing subjects’, thereby reflecting aspects of care (Gunzenhauser, 2006: 627) and, in particular, mutual respect, dignity and connectedness between the researcher and researched. Scholars who take this approach see the solutions to ethical conflicts as being consensually determined, thereby encouraging sympathy, identification and connectedness towards the individuals under research. I will argue,
however, that in practice ethical decisions are not necessarily driven by a desire for consensus. Instead they may be motivated by scepticism, ambition, belief and mistrust, which may lead to or help fuel controversy.

Acknowledging the potentially conflict-ridden field of CAM in Denmark, I introduce a ‘controversy perspective’ to the contemporary debates on research ethics. The advantage of this perspective is that social and political processes that are usually hidden become dramatically apparent (Scott et al., 1990). My approach is based on the premise that the political dimensions of knowledge production and use emerge most vividly in live controversies where the boundaries between politics and science are contested (c.f. Collins, 1991; Ezrahi, 1990; Latour, 1990; MacKenzie, 1990; Scott et al., 1990; Social Studies of Science, 1996). The increasing popularity of CAM treatment in Denmark, and the fact that it is excluded from the officially subsidized Danish health care system, mean that, where CAM is concerned, the boundaries between politics and science are constantly being challenged. In my view, therefore, ethics should be seen as a political practice characterized by conflict. Research ethics are ‘political’ in the sense that scientific knowledge is used strategically to support specific knowledge interests. By treating ethics as a field of controversy I imply, in practice, that ethical decisions in research are based on the researcher’s recognition of antipathies, disbeliefs, discrepancies and diverging political interests in relation to how the knowledge is used.

What follows is an introduction to CAM in Denmark as the particular subject matter of the present research.

**CAM in Denmark**

The Danish health care system is organized into primary, secondary and tertiary sectors respectively involving general practitioners (also known as family doctors), tax-financed hospitals (including central blood and serum laboratories, outpatient clinics and various specialists) and private hospitals and sports clinics. Alternative therapies are not officially acknowledged in the system and this non-inclusion reflects the age-old gap between conventional and alternative medicine, biomedicine being the established form of medicine in this country.

Since the 1960s there has been a marked growth in consumer interest in CAM in western societies. Clients’ use of CAM has often been linked with rehabilitation and the minimizing of risk and pain (cf. e.g. Ahn and Kaptchuk, 2005; Arman and Rehnsfeldt, 2003; Baer, 2003). So far, however, there has been little or no evidence from a biomedical perspective that CAM is effective in this regard, and the reasons why clients choose to pursue CAM appear to be more complex (e.g. Boon et al., 1999, Foote-Ardah, 2004; Testerman et al., 2004; Sointu, 2006). A recent study in Denmark estimates that nearly half the respondents have drawn on the services of alternative practitioners, and two out of 10 have used an alternative practitioner within the past year (Lønroth and Ekholm, 2006). Accordingly, the
number of CAM practitioners has expanded rapidly. This increase generates a problem of consumer confidence. It is assumed that the alternative sector in Denmark includes an unknown number of frauds whose incompetence or ignorance may diminish the reputation of, and confidence in, trained alternative practitioners. Although the trained practitioners are organized in various associations (e.g. the Danish Reflexologists’ Association and the Danish Acupuncturists’ Association), clients risk being deceived by those who claim to be professional but whose skills and methods have not been certified. Not surprisingly, the field of CAM is vulnerable to the damage that may be caused by such frauds. Trained practitioners and their associations are consequently eager to be accorded the same legitimacy as the established biomedical professions. Such professional acceptance might also lead the government to grant subsidies for treatment, which would in turn provide the alternative sector with greater financial resources and stimulate more clients to seek out alternative therapies. So far, however, its position of exclusion makes CAM a field of controversy concerning forms of knowledge, definition of effect, recognition and accreditation. These controversies became very apparent in the course of our research meetings.

The controversy

A controversy emerged during a meeting between researchers and practitioners when a practitioner criticized the fact that, in the study, half of the clients involved in one particular form of therapy (a form practised by five of the practitioners present) were being treated by one particular practitioner. The practitioner who raised the issue questioned the usefulness of the research in this respect, on the grounds that – as she argued – bodily sensations are the result of the specific practitioner. ‘If one is really interested in what happens in the encounter between client and practitioner’, she said, ‘one needs as large a variation [among practitioners] as possible.’

On the face of it, this critique relates primarily to the design and validity of the research, with the practitioner calling implicitly for a randomized design that would, in her opinion, strengthen the validity of the results. However, our research was strictly qualitative and located in a completely different knowledge regime. The controversy thus reflects well-established debates about the nature of scientific knowledge and, in particular, the practitioners’ quest for evidence-based knowledge on the effects of CAM rather than knowledge produced by interpretative traditions. Second, the critique emerged from CAM’s exclusion from the Danish health care system, which has prompted a strong desire on the part of the practitioners to prove that CAM has positive effects in relation to the clients’ health problems. In the context of the present research, however, this focus on positive effects is particularly paradoxical, since the practitioners themselves were asked to recruit clients with whom they anticipated a successful course of treatment, and one would therefore expect them to report positive effects that they ascribed to the treatments. Hence, no matter
the research objective, the practitioners’ participation and critique has a subtext: hopes for demonstrably positive effects and strategic use of the knowledge produced to demonstrate that CAM works. These aspects, however, strictly belong to the subject matter of CAM in a Danish context. They are not the subject of the present research project. Nevertheless, the critique articulated by the practitioner raises the question of the relationship between science and politics, emphasizing that the knowledge produced in this research – whatever it is – has direct policy implications.

At the concrete level, we – the researchers – responded to the criticism by pointing out that the study was not designed as a comparative study between practitioners, or between clients or clinics. We also argued that, regardless of the particular clinics and practitioners involved, the focus of the study was on the clients’ bodily sensations rather than on the skills of the practitioner. Finally, we argued that it was indeed important to secure variation among the clients, and that this was achieved by the selection criteria developed in collaboration with the practitioners. In addressing the conflict between the practitioner’s desire to prove the effectiveness of CAM through randomized trials, versus our decision to situate the present research within the interpretive tradition, we referred to the methodological literature within the social sciences and argued that the unequal distribution of clients does not pose any problem with regard to the research objective. By rejecting the practitioner’s critique with reference to acknowledged scientific standards, including the content of the approved research protocol, we were marking out the roles stated in the collaboration contracts, emphasizing that the researchers were responsible for the scientific aspects of the research, while the practitioners were responsible for the practice of CAM.

The practitioner’s critique posed a serious threat to the continuation of the research project. Because the continued research depended on collaboration with the practitioners, the ethical dilemma for the researchers was how to address the criticism in a constructive manner: how, among other things, to define domains of responsibility respectfully and honestly, in order to defend our academic freedom, while still maintaining the positive collaborative relationship that the research relied upon. Thus the dialogue between the researchers and practitioners not only carried a subtext on the part of the practitioners, but on the part of the researchers as well.

We did not succeed in reaching a consensus on the matter during the meeting with the practitioners. The collaboration contracts we had drawn up reflected only the tendency to neutralize or depoliticize a de facto political relationship by attempting to constitute the professional roles in isolation from the political context in which they inevitably operate. The collaborative nature of the research certainly posed challenges to the academic independence of the researchers, making them feel stuck in the middle. The meeting did, however, enable us to articulate conflicting perspectives on the design of the study and
differing points of view on its consequences for scientific knowledge. Since then the disagreements have not been discussed, and we have begun to analyse the empirical data. Recently we presented some initial analyses concerning clients’ bodily sensations in a nationally well-known forum called ‘Meet Science’. The practitioners present on this occasion were very pleased with the results, and it seems likely that the presentation has calmed troubled waters.

**Conceptions and convictions**

Researchers formulate research questions and topics, and in collaborative research it is likely that these topics will also reflect the interests of the object of study. This gives rise to ethical questions concerning the nature of our commitment (to whom or to what are we committed?) and of our own beliefs. What follows is a discussion of how conceptions and convictions influence communication between researchers and collaborators and how beliefs and commitments are constructed.

In the present research the potential for controversy between the researchers and collaborators was obvious. No matter what we said or how we disseminated our information, the practitioners remained focused on the idea that our study would provide scientific legitimation of CAM’s positive effects. Morally, we were placed in a position where we were obliged constantly to remind practitioners that the knowledge produced would not provide them with strong evidence, or even a vague hint as to whether their particular treatment actually ‘worked’. As researchers, moreover, we found ourselves in the position of bartering, where the only thing that we could exchange for the hope and goodwill of the practitioners was our professional interest.

The situation derives from the moral asymmetry inherent in qualitative research concerned with human experiences. Such research is ethically ambiguous, because no matter how well informed the collaborators are, the relationship between the researcher and the collaborators rests on a set of what Geertz terms ‘partial fictions half seen-through’ (2000: 34). The researcher’s interest is sustained by the scientific value of the data being produced, while the collaborators’ interest lies in being part of an important scientific – and for them political – enterprise; in this case the enterprise of contributing to the higher purpose of validating the effect and legitimacy of CAM.

Although scientific knowledge has political and policy consequences, there is no epistemological seam between political and scientific actions (Collins, 1996: 232). Still, the researcher must act as if everything that is said is primarily political, and in this case the research may produce spaces or opportunities that the practitioners may exploit – sometimes in ways that the researchers do not intend, foresee or condone. This is part of the game of being caught between politics and science, but it means that ethical considerations arise throughout scholarly practice.
BELIEFS
The fact that demonstrating the positive effects of CAM was not part of our agenda also generated a desire on the part of the practitioners to inculcate in the researcher a belief in the efficacy of CAM. When I first met the practitioners, they asked me whether I had any personal experience of CAM. My experiences were restricted to a single occasion, 17 years ago, when I had consulted a healer. I did not lie about my experience, but neither did I share with them my scepticism about CAM. I interpreted their queries to mean that, had I had such experiences, this would incline me to be ‘on their side’ in the collective struggle to produce evidence of the effectiveness of CAM: showing that, yes, it ‘works’.
During the research, the clients whom I interviewed told me about their bodily changes and sensations, most of which they ascribed to the therapeutic treatment by CAM practitioners. When I asked them specifically whether they believed the therapies worked, they responded in ambiguous ways: ‘I don’t know. It must.’ Or ‘Something happens. Whether it is the treatment or something else, I don’t know.’ Their experiences, and my own one-off experience of healing, did not help me to clarify my own belief. Being stuck in the middle of a controversy between various conflicting discourses, conceptions and convictions – between different moralities and epistemes – made me feel as if I were being dishonest. The dilemma was how to show collaborators and research subjects (the clients) my ‘true’ face (Pels, 2000: 137). Despite the fact that my own research is situated in regimes of truth far from evidence-based medicine, I found myself caught up in the politics of the research field and of biomedicine as the dominant regime of truth. I considered the practitioners’ question fairly ‘innocent’, but I was still aware of the risk of being positioned as a partisan for their cause if I told them that I had actually sensed something happening when I underwent healing. I attempted to show a degree of neutrality towards the subject matter by not inviting the practitioners in on my experiences and by refraining from articulating the scepticism towards CAM that I also feel. I shall return to the question of neutrality later.
As the research process unfolded and the above-mentioned controversy occurred, I gradually became more aware of my own stance towards CAM. It was particularly agonizing for me to realize that our research efforts were likely to be – from my point of view – misused as supposed evidence for the positive effects of CAM, even though we had not in fact set out to investigate whether CAM was effective or not. My personal beliefs were further challenged when my partner one day suggested that our one-year-old son be given reflexology treatment for his continuous inflammation of the middle ear. The fact that I did not want my own son to undergo this treatment made me realize that up until then I had not known how sceptical I was towards the subject matter of my own research. Although I am familiar with all the interviewees’ stories of bodily sensations ascribed to CAM, I am not personally convinced that CAM is not just an expensive experience. This certainly influenced my attitude in dealing with the controversy. Had I been committed to the cause of producing
evidence for the positive effects of CAM, I might have acknowledged the practitioner’s reservations about the kind of knowledge our research would generate. Instead, I argued strongly for our academic freedom and the value of scientific knowledge in its own right, reminding the practitioners that our research objective was not concerned with the effects of CAM.

COMMITMENT

Conducting ethically sound research does not, however, require that the researcher agree with the beliefs of the researched. Being ethical does not entail ‘motivational displacement’, i.e. does not require that the researcher set aside their own goals to focus on those of their collaborators (Gunzenhauser, 2006: 625). To suggest otherwise is to misunderstand what ethical caring means. The problem arises when the researcher is not convinced that the research is valuable, thereby making the research, and their relationships in the field, seem inauthentic. The researcher must be committed to their research (Liberman, 1999: 51). As it became more apparent that the practitioners were hoping and attempting to use the scientific knowledge generated as evidence of the positive effect of CAM, I became committed to exploring the empirical phenomenon that many clients continue treatments even when these fail to relieve them of their health problems. Thus I defined a critical project that has so far resulted in the publication of a journal article (Baarts and Pedersen, 2009) concerned with identifying the grounds for continuing to undergo CAM treatments even in the absence of positive effects. Although the critical project is empirically and theoretically relevant, I was motivated in defining it partly by my desire not to become involved in a de facto partisanship with the practitioners.

Scott et al. (1990) discovered that groups or individuals with fewer scientifically or socially legitimated resources are by definition more likely to attract the researcher, while those with greater resources are more likely to view the researcher and his/her analysis with suspicion and reserve. Thus researchers interested in CAM may be tempted to commit to or be ‘taken hostage’ by CAM practitioners. But of course there are never only two sides to a controversy. Various third positions represent different mixtures of involvement and detachment as well as the lack of a privileged point of view (Pels, 1996).

Whatever position the researcher chooses, however, it seems that commitment to commitment is a generally accepted requirement in science (Collins, 1996). However, ‘commitment to commitment seems to imply commitment to some cause or other, even before a cause has been evaluated’ (Collins, 1996: 231). To quote Gouldner (1968: 105): ‘A commitment made on the basis of an unexamined ideology may allow us to feel a manly righteousness, but leaves us blind’. Qualitative studies that are motivated by any prior commitment will necessarily be intellectually impaired unless they clarify the grounds for such commitment (1968: 105). My commitment to the present critical project was motivated by the desire to avoid being regarded as partisan in a partisan relationship that I do not approve of. My aim moreover was to explain the
increased popularity of CAM not by reference to its positive results but in terms of already known characteristics of contemporary society, such as the increased emphasis on individual responsibility for personal health.

With hindsight I see that I should have acknowledged and articulated my scepticism more thoroughly during my collaboration with the practitioners. I should have recognized that ethical research does not imply a comfortable sort of neutrality, and that taking a standpoint as a researcher means adopting a third position distinct from both the dominant and the marginal positions within the controversy. Had I expressed my scepticism, the practitioners might still have seen me as a potential ‘convert to their cause’. Taking a stand within the framework of highly politicized and commercialized subject matter, and making that position public, is part of conscious ethical practice, and at the same time reflects the recognition that science is both partial and political. Taking a stand does not necessarily imply communicating everything to collaborators or participants. But it does mean that one must reflect on the part played by one’s personal values and beliefs. Thus, ethical research requires personal authenticity in the way one positions oneself in relation to the subject matter.

**The ethical researcher**

Foucault argues that ethics is ‘an intensification of the relation to oneself by which oneself constitutes oneself as subject of one’s acts’ (Foucault in Cannella and Lincoln, 2007: 322). This places the moral life of the researcher in the forefront, dissociating him/her from universalist moralities such as codes of conduct. In social science health research, however, qualitative researchers seeking to collaborate with health professionals such as physicians are confronted with procedural ethics. In the area of biomedicine the principal code of ‘informed consent’ is a standard prerequisite. However, such codes of procedure ignore the social and cultural context in which the process of consent takes place (Corrigan, 2003), and consequently the moral life of the researcher. Hence procedural regulation reduces morality to a mere set of guidelines for conduct, rather than a continuous (re)constitution of the self. Through procedural regulation, the researcher’s self is kept isolated from the real world, and the researcher remains under the illusion that he or she is free of the contaminating influence of politics and knowledge interests. This creates a problem in determining what actually constitutes ethical behaviour. Ethics is not grounded in prescriptions, norms and ideals external to society. Rather, it is located in the social, the cultural, and the political. Ethics is close to the ground. And it is on the ground that the moral life, the life of decisions and practices, takes place (Christians, 2007: 438).

It goes without saying that an ethical researcher possesses a certain kind of judgement in determining what actions are ethically appropriate. In some
situations this may involve finding the right mean between conflicting codes, in others it may not necessarily involve any knowledge at all of the codes of conduct or other kinds of procedural regulation. In all cases, however, the researcher needs practical wisdom (Lakoff and Collier, 2004: 423) of the kind that will enable him or her to act on the basis of the particular requirements in each fresh context. Practical wisdom is linked to the character of the individual, and can be exercised only by a person who has been educated into ethical life. Thus, practical wisdom can be achieved only by engaging oneself in the controversies that emerge during research. The qualities of the ethical researcher are thus not moral universals, but qualities that enable the researcher to navigate between politics and science. In relation to the controversy and the ethical issues discussed above, we can highlight four such qualities: discernment, imagination, partiality and personal authenticity. Let me discuss these four qualities in turn.

**DISCERNMENT**

Research ethics are grounded in the researcher’s knowledge of the particular subject matter in question: both scientific knowledge on the topic and insight into the role and status of the subject matter in society. Conscious ethical practice requires discernment, i.e. the ability to discern and to consider carefully the knowledge-political interests present in the given field of research, in this particular case the conflict-ridden field of CAM. To practise ‘discernment’ the researcher needs to be as up to date as possible on the scientific knowledge within the field and to be well informed on the political debates and struggles, such as discourses of accreditation and recognition, that are associated with it. The complexity of any research field leaves room for indeterminacy in delineating controversies and resolving the ethical dilemmas that accompany them. The inherent uncertainty involved always makes an ethical decision ‘greater’ than the researcher her/himself. Yet in attempting to understand this complexity the conscious ethical researcher needs to bring discernment into play.

**IMAGINATION**

Discernment entails an ability on the part of the researcher to imagine the consequences of his/her choices and actions. The researcher’s knowledge and experience do not by themselves provide a sufficient basis for sound judgement and ethically correct action. The researcher needs strong powers of imagination as well.

The ethical researcher must be capable of visualizing situations and foreseeing the consequences of possible acts or thoughts in such situations; in the present case, for instance, the consequences of the practitioner’s critique and of our response for future research collaboration, as well as their implications for our academic freedom and independence. Several scholars (Cannella
and Lincoln, 2007; Clark and Sharf, 2007; Guillemin and Gillam, 2004) have already identified reflexivity as a means to practise ethics, arguing that we need to recognize the complexity and contextuality of research ethics in order to learn from other researchers’ experiences in developing a more reflexive practice. By themselves, however, mental activities do not make human beings ethical, and reflexivity is a mental activity that includes only the reflective self. Reflexivity and contingency are part and parcel of any (critical) science. It is reasonable to expect a researcher to exercise discernment and imagination, even though parts of the controversy situation under research may remain inaccessible, obscured by the limits of our imagination and moral awareness.

**PARTIALITY**

Because scientific knowledge has become so politicized, any research project is intertwined with political issues. This means that the researcher will inevitably find him/herself taking a position contrary to that of certain other scholars in the field, some of whose accounts may be widely accepted versions (Jasanoff, 1996: 12). The present research, for instance, is likely to be interpreted as either ‘for’ or ‘against’ CAM. Although neutrality has always been upheld as an ideal in science, it may not be an appropriate goal for which to strive. Neutrality implies a monovalent position that does not encompass multiple other dimensions (Wynne, 1996: 360). Even as a general orientation, neutralism cannot possibly reflect the complexity of the world in which we live and which we seek to explain. Science is neither value-free, nor impartial.

Collins (1996: 237) argues that researchers should begin their analysis without commitment and wait to commit themselves until they know who appreciates the research or the analysis. Although this sounds controversial or unethical, it does not necessarily imply that the researcher commits herself to all those who support her conclusions. Being partial, according to Collins, may be part of the science-political game.

In conflicts involving a field such as CAM, we may tend to think of the supporters or practitioners of alternative therapies as the underdogs. Yet underdogs can become top dogs, and the researcher should not commit him/herself in advance to a specific side of the controversy. Nevertheless, if a preference for the underdog is in some way expected or prescribed by the way research questions are posed or methodologies practised, this preference should be openly articulated as an element of the research project (Collins, 1996: 237).

Ethical decisions are not per se consensus-driven. As we saw in the controversy discussed above, ethical action on the part of the researcher may consist in clearly acknowledging a partiality that may not accord with that of collaborators in the research. Behaving ethically means taking a stand by bringing discernment and strong imaginative powers reflexively into play and by becoming (more) articulate and thus explicit about one’s preferences. Thus, partiality assumes ambiguity and is also a precondition for being articulate. The ethical researcher becomes partial as the research act unfolds.
PERSONAL AUTHENTICITY

Partiality commits the researcher to being personally authentic in his/her choices and actions if s/he is to be trusted in future controversies and collaborative research. ‘Personal authenticity’ implies that the researcher must not deceive themselves concerning the grounds for the choices they make. They need to pay heed to the relationship between personal beliefs about the actual state of the social world on the one hand, and their wishes, hopes and values for this social world on the other. Personal authenticity depends on the researcher’s ability and willingness to acknowledge facts that may not accord with their own hopes and values. In order to practise personal authenticity the researcher needs to be aware of the complexity of any ethical situation that requires them to be articulate and self-aware about their choices and actions.

In asserting that ethical decisions should be authentic across controversies, the researcher presupposes a certain amount of ethical knowledge and experience. The researcher must be able to draw on their own powers of discernment with reference to the particular field of research, and to use their imagination in extrapolating from the experience and controversies of other scholars in other fields. Thus, personal authenticity in ethical decisions depends not just on the nature of the choices taken and the motivation for them, but on the relationship between the choices made in the given instance and those made in previous controversies.

Since the consequences of an act may be imagined at any number of different times, there is nothing to indicate that the researcher should always react in the same fashion to the imagined consequences of a particular act. The researcher’s ethical choices may be both restricted and stimulated by the extent of their imagination, knowledge and experience of the subject matter. Thus personal authenticity does not rule out transformation and personal growth.

Concluding remarks

The political aspects of the field of research that I have described in this article, with reference to the ethical questions to which it gives rise, neither reinforce nor diminish the division between biomedicine and CAM. Nor do these political issues introduce new axes of difference or new political or scientific categories. The political issues at stake revolve around established controversies concerning the body, the nature of belief, the validity of knowledge, the range of truth and the demonstration of efficacy. While belief, truth and efficacy are elements of different modes of ordering the world, they also continue to be human experiences (Mol and Mesman, 1996: 436). Politics may be about medicine, but medicine is also about politics. Politics may also be about science, but it exists within science too. Every controversy is caught up in a range of evaluative logics or third positions. There is never a single system for assessing or comparing different positions; rather, the complexity of the field means that there are many such systems (1996: 436).
This complexity in the relationship between science and politics expands in the totality of scholarly practice, and makes ethical considerations relevant throughout the research process. Caught between science and politics, the practice of ethics requires discernment, imagination, partiality and personal authenticity. Since it is now ‘acceptable’ to acknowledge openly the interconnections between science and politics, the ethics of embedded research must consist in a defence of the importance and relevance of the particular object of study and an acknowledgement of partial knowledge.

Hence, the researcher should begin any research by systematically identifying and critically examining the scientific and political values at play in the field generally, and those implicit in the particular subject matter, research question, theoretical perspective and methodology, as well as by looking at the specific institutions or technologies under research. Such analysis constitutes the basic pre-analytic requirement for framing knowledge-commitments and possible controversies.

The controversies discussed in this article were not particularly extraordinary. Nevertheless, it was impossible to avoid them through procedural regulation, i.e. through professional codes of conduct. Every research process includes controversies that cannot be pre-regulated and solutions that cannot be pre-planned. No code of ethics can account for all these situations. No matter how attentive and preventive we researchers intend to be, no matter how strict our codes or how vigilant our IRBs are, controversies will emerge that will continue to make us feel caught in the middle.

Acknowledgements

I gratefully acknowledge the extremely helpful comments of Anders Blok on an early version of this article.

Notes

1. The term ‘underdog’ derives from Howard S. Becker’s paper ‘Whose side are we on?’ (1967) in which he states that it is impossible to do research that is uncontaminated by personal and political sympathies, and that no matter what perspective a researcher takes, his/her work must be written from either the standpoint of the subordinate or that of the superior.

2. Whereas reflexology and acupuncture are fairly well known, mindfulness training may be less familiar. Mindfulness can be described as a specific, embodied, intentional orientation towards ‘paying attention in a particular way, on purpose, in the present moment, and non-judgmentally’ (Kabat-Zinn, 1994: 4). Mindfulness training is focused on the cultivation of conscious awareness and attention from one moment to the next in an open, curious and accepting way (e.g., Bishop et al., 2004; Germer, 2005; see also Stelter, 2007).

3. The study is based on interviews with 46 clients equally distributed among the three therapies. We conducted a total of 138 interviews. Each client was interviewed three times – at the beginning, middle and end of the course of treatment – and observed during treatment before the first and second interviews were conducted.
4. Recently, however, there have been indications of a change in the relationship between bio- and alternative medicine in Denmark, as some tax-financed hospitals – for instance the obstetric ward of the university hospital, Rigshospitalet – now offer acupuncture to women giving birth as a supplement to drug-based pain management. Moreover, private fertility clinics offer acupuncture before and after insemination or the implantation of the fertilized egg.

5. This particular meeting was tape-recorded.

6. Due to the collaborative nature of the present project, contracts of collaboration were drafted between researchers and alternative practitioners. These contracts set out general principles for collaboration and mutual communication between researchers and collaborators. They also defined the roles of the researchers and the collaborators, and described the rights and obligations of the respective parties in relation to the production and analysis of empirical data on the practice of CAM. Finally, the contracts dealt with publications and communication with the press, and included guidelines on how to solve potential conflicts.

REFERENCES


CHARLOTTE BAARTS is an Associate Professor at the Department of Sociology at the University of Copenhagen, Denmark where she specializes in teaching advanced qualitative methods. Her research focuses on health, including safety and occupational health, and on work and working life. She is currently involved in research within the field of complementary and alternative medicine. Address: Department of Sociology, University of Copenhagen, Øster Farimagsgade 5, P.O.B. 2099, DK-1014 Copenhagen K, Denmark. [email: cba@soc.ku.dk]