LEGITIMATING OUTCAST PRACTICES: PROFESSIONAL CONTESTATION OVER INTRODUCTION OF TRADITIONAL AND COMPLEMENTARY MEDICINE INTO THE TURKISH HEALTHCARE SYSTEM, 2014-2018

A THESIS SUBMITTED TO

THE INSTITUTE OF SOCIAL SCIENCES

OF

ANKARA YILDIRIM BEYAZIT UNIVERSITY

BY

HASİBE AYSAN

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS

FOR

THE DEGREE OF DOCTOR OF MANAGEMENT AND ORGANIZATION

IN

THE DEPARTMENT OF BUSINESS ADMINISTRATION

JANUARY 2019

APPROVAL PAGE

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I hereby declare that all information in this thesis has been obtained and presented in accordance with academic rules and ethical conduct. I also declare that, as required by these rules and conduct, I have fully cited and referenced all material and results that are not original to this work; otherwise I accept all legal responsibility.

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ABSTRACT

In this dissertation, I examine legitimation as a multidimensional process, which involves interactions between entities (such as practices or organizational forms), legitimacy criteria by which these entities are evaluated (such as regulative or normative), and legitimators (such as professionals or the state). Specifically, I examine legitimation of a bundle of outcast practices as driven by a heterogenous community of professionals mobilizing diverse legitimacy criteria and the ensuing contestation. My empiricial context is integration of traditional and complementary medicine (TCM) into the Turkish healthcare system (THCS), which was initiated in 2014 by the Turkish Ministry of Health through a bylaw that regulated 15 different TCM practices, allowing them to be performed by medical doctors (MDs). In order to examine how legitimation process unfolded within this context, I designed a qualitative research encompassing the period 2014-2018 during when I collected interview data from medical professionals. I also used other data sources to collect background information. Results from qualitative analyses revealed that legitimacy of TCM practices is not resolved once and for all but instead the process unfolds in a multidimensional space made up professionals with divergent ideologies, their varied legitimacy criteria, and a variety of practices. The outcome is contestation characterized by an emergent schism within the profession as to legitimacy of TCM practices, establishment of new criteria according to which adequacy of medical practices can be evaluated, and divergence in the extent to which individual TCM practices are considered as legitimate. As I conclude this dissertation, I argue that studying legitimation as a multidimensional process may help capture overall complexity and critical dynamics of this process and avoid biases that emenate from a unidimensional conception.

ÖZET

Bu çalışmada meşrulaşma sürecini, meşrulaştırılan varlıklar (uygulamalar ya da örgütsel formlar gibi), bu varlıkların değerlendirildiği meşruiyet kriterleri (yasal ya da normatif meşruiyet gibi) ve meşruiyet değerlendirmesi yapanlar (profesyoneller ya da devlet gibi) arasındaki etkileşimi içeren çok boyutlu bir süreç olarak inceledim. Özellikle, dışlanmış bir grup uygulamanın meşrulaştırılmasını, heterojen bir topluluk olarak profesyoneller tarafından çeşitli meşruiyet kriterlerinin harekete geçirilmesi ile yönlendirilen ve akabinde oluşan bir çatışma süreci olarak inceledim. Araştırmamın görgül bağlamını, 2014 yılında Sağlık Bakanlığının yayımladığı yönetmelikle 15 farklı Geleneksel ve Tamamlayıcı Tıp Uygulamasının (GTTU) doktorlar tarafından uygulanmasına izin verilmesi yoluyla Türk Sağlık Sistemi'ne (TSS) eklemlenmesi oluşturdu. Bu bağlamda, meşrulaşma sürecinin nasıl geliştiğini inceleyebilmek için, tıp profesyonellerinden mülakat verisi topladığım ve 2014-2018 yılları arasındaki dönemi kapsayan nitel bir araştırma tasarladım. Ayrıca diğer veri kaynaklarını da arka plan bilgisi edinmek için kullandım. Nitel analiz sonuçları gösterdi ki, GTTU'nın meşrulaşması bir seferde kesin olarak çözülebilen bir süreç değil; birbirinden farklı ideolojilere sahip profesyonellerin, onların değişen meşruiyet kriterlerinin ve çeşitli uygulamaların oluşturduğu çok boyutlu bir düzlemde gelişen bir süreçtir. Ortaya çıkan sonuç, GTTU'nın meşruiyeti, tıbbi uygulamaların uygunluğunun değerlendirilmesi için yeni kriterlerin oluşturulması ve her bir GTTU'nın meşru kabul edilmesi noktasında ortaya çıkan farklılıklara ilişkin meslek içinde ortaya çıkan bölünmenin karakterize ettiği bir çatışmadır. Çalışmayı bitirirken, meşrulaşmayı çok boyutlu bir süreç olarak çalışmanın, sürecin tüm karmaşıklığını ve kritik dinamikleri yakalayabilmekte yardımcı olacağını ve tek boyutlu kavramsallaştırmanın neden olduğu yanlılıklardan uzak durabilmeyi sağlayacağını ileri sürmekteyim.

DEDICATION PAGE

I want to dedicate this dissertation to the medical professionals in the Turkish healthcare system, whether they directly participated in this study or not, for their incredible efforts for healthcare provision in Turkey.

I further dedicate this dissertation to my husband, for his support and encouragement throughout my PhD studies.

Finally, I dedicate my whole efforts to my parents, for their long-lasting support for reaching my dreams ever since my childhood.

ACKNOWLEDGMENTS

I wish to express my deepest gratitude to my supervisor, Prof. Dr. Çetin Önder, for his guidance, advice, criticism, encouragement, and insight throughout this research. I would also thank to Prof. Dr. Şükrü Özen and Prof. Dr. Ali Danışman for their suggestions and comments as thesis observation committee members. The contributions and evaluations of other defense jury members, namely, Asst. Prof. Dr. Selin Erdil Eser, Prof. Dr. Kerim Özcan, and Assoc. Prof. Dr. Mustafa Çolak are also gratefully acknowledged.

This dissertation was supported by the Scientific and Technological Research Council of Turkey through the National Doctoral Scholarship Program (2211-A). Therefore, I extend special thanks to the Scientific and Technological Research Council of Turkey (TÜBİTAK).

I am grateful to Leslie Demir for her contributions to language editing and her friendly motivation.

Finally, I wish to express my gratitude to my husband, Mehmet Necati Aysan, and my son, Fuat Alp Aysan for all the patience and help they provided during this process; to Mahi, for all of her assistance at home; to my parents, for all the support they have provided; and to all of my friends who motivated and supported me throughout this process.

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LIST OF ABBREVIATIONS

TCM	Traditional and Complementary Medicine
THCS	Turkish Healthcare System
PNMD	TCM practitioners without medical degree
MD	Medical Doctor
TMOH	Turkish Ministry of Health
TMA	Turkish Medical Association
WHO	World Health Organization
Law 1219	Tababet ve Şuabatlarının Tarzı İcrasına Dair Kanun (*Regulation for Mode of Execution of Medicine and its Branches*)
Law 1960	Tıbbi Deontoloji Nizamnamesi (*Medical Deontology Regulation*)
YÖK	Higher Education Institution
UR	University Reform
EAH	Education and Research Hospital
SGK	Social Security Institution of Turkey
RCT	Randomized controlled trials
GTTU	Geleneksel ve Tamamlayıcı Tıp Uygulamaları
TSS	Türk Sağlık Sistemi

1. INTRODUCTION

The rise of modern healthcare systems in developed parts of the world almost invariably entailed exclusion of traditional and complementary medicine (TCM) and denigration of its metaphysical premises, which were replaced with a positivistic view that buttressed reductionist, deterministic, and objectivistic research in medicine (Coulter, 2003). This process was noticeable as early as the mid-19th century and continued well into the 20th century, though at different paces or following different patterns across different nations (Ebrahimnejad, 2008; Saks, 2005). The Turkish healthcare system (THCS) experienced a similar scientization process that began with the establishment of a military medical school in the early 19th century during the Ottoman period and intensified with the transition into a republican regime in 1923, characterized by attempts at top-down modernization of an essentially traditional society following the Western blueprint (Ceylan, 2012; Erdem, 2012; Günergün, 2013).

Nevertheless, in the past few decades, TCM has managed to make significant inroads into modern healthcare systems (Broom & Tovey, 2007; Goldstein, 2002; Mizrachi, Shuval, & Gross, 2005). Most notably, the World Health Organization (WHO) has had a TCM strategy since 2002 and member states have been increasingly erecting relatively comprehensive TCM policies. Turkey has also been experiencing similar changes, albeit belatedly. In 1991, a bylaw that regulated application of acupuncture (see Appendix D for a description) by medical doctors or dentists was passed. After a series of patchy attempts at legislating sales of herbal or homeopathic drugs and remedies (see Appendix D for a description of homeopathy and homeopathic drugs and remedies), a collection of 15 TCM practices (including acupuncture) were regulated by another bylaw passed in late 2014. This bylaw set generic rules as to training, certification, and practice. Upon gaining regulative legitimacy, application of TCM practices began diffusing across public and private settings, such as hospitals and clinics. Certificate programs also increased in number around the country.

The regulation brought about significant contestation among healthcare professionals, especially medical doctors (MDs), as to the legitimacy of TCM practices. For instance, the Turkish Medical Association (TMA) demanded repeal of the bylaw. This request was ultimately rejected by the Council of State (Danıştay) in May 2018. There are professionals

who oppose TCM practices and challenge their legitimacy with claims such as lack of reliable research results proving effectiveness of TCM practices and the risk of exploitation of patients by promoting TCM practices as if they had no side effects (Oğuz, 1994). There are also arguments regarding the unnecessary emphasis on religious aspects of some TCM practices, even if they do not provide more than a placebo effect[1] (Oğuz, 1994).

On the other hand, some professionals who support TCM practices in the THCS claim that healing people should involve consideration of the physical body of the patient together with his or her psychological state (Mollahaliloğlu, Uğurlu, Kalaycı, & Öztaş, 2015). Some studies have been conducted in an effort to obtain reliable proof about effectiveness of some TCM practices, as well (Vulkan & Yıldız, 2016). Furthermore, there are some professionals positioned in between these two opposing groups, who accept the applicability of some TCM practices such as acupuncture or hypnosis, which may have the potential to support modern medicine, and thus argue that rejection of them without adequate research is nonscientific (Mollahaliloğlu et al., 2015).

Hence, medical professionals of the THCS fall into a schism regarding the legitimacy of TCM practices and its integration in to the system. These actors are products of science-based medical training and are presumably guardians of modern medicine. Arguably, their collective resistance would negate efforts at the introduction of TCM. However, TCM is being incorporated into the THCS all the same. Although it might be assumed that professionals would evaluate any legitimated entity in a field with the same standards, professionals in the THCS seem like evaluating TCM practices on different grounds.

TCM practices regulated by the 2014 bylaw differ from each other in various respects. Some of the regulated practices are deeply embedded in the religious beliefs or traditions of the Turkish people and have had ample opportunity for survival outside of the healthcare system; therefore, they have been widely practiced in unmodernized spheres of society in spite of being viewed as inferior by medical doctors. On the other hand, there are other TCM practices that are not embedded in Turkish culture or did not originate from this context.

[1] Placebo effect is assumed as control attributes cannot and should not be ignored during a research process.

Therefore, professional contestation regarding legitimacy of TCM practices reflects that there are multiple evaluations of those professionals regarding various TCM practices of various origins in the THCS.

Legitimacy has been a central construct of organizational studies (see Deephouse, Bundy, Tost, & Suchman, 2017; Suddaby, Bitektine, & Haack, 2017), and it is studied in different ways. First, it is studied as a resource or property (Dowling & Pfeffer, 1975; Suchman, 1995) that reflects the fit between environmental requirements and the entity being evaluated (Suddaby et al., 2017). Second, it is studied as a process that reflects constructive social interaction among different stakeholders in evaluating an entity's properties (Suddaby et al., 2017; Suddaby & Greenwood, 2005). Finally, it is studied as a perception that reflects cognitive judgment processes of individual stakeholders (Bitektine & Haack, 2015; Suddaby et al., 2017; Vergne, 2011).

The common feature of legitimacy studies is that all of them include some form of evaluation of an entity against some legitimacy criteria. On the other hand, the majority of legitimation studies consider only one dimension. For example, some of them focus on entities to be legitimated, such as a new venture (Fisher, Kotha, & Lahiri, 2016; Navis & Glynn, 2010) or a new product (Laïfi & Josserand, 2016; Lounsbury & Crumley, 2007). Those studies consider the entity as something unitary or homogeneous that is new to the field. On the other hand, the legitimation of entities that do not constitute a homogeneous form and are not new to the field has not been studied properly.

Another deficit of legitimation studies is that the majority of them focus on only one legitimacy criterion, such as regulative legitimacy (measured by the approval of governmental authorities) (Dobrev, 2001; Kwiek, 2012), normative legitimacy (measured by the approval of professionals) (Ruef & Scott, 1998), or cultural cognitive legitimacy (measured by the prevalence in the public sphere) (Vaara, 2014). There are some scholars who accept the multiplicity of dimensions in legitimation (Fisher, Kuratko, Bloodgood, & Hornsby, 2017; Laïfi & Josserand, 2016), although they do not explain the interactions among those dimensions.

Moreover, extant literature on legitimation by professionals considers professionals as a homogeneous group of experts who share common ideas about legitimacy criteria in their

judgments. Professionals are occasionally accepted as providers of normative standards and their mobilization of various legitimacy criteria has not been studied properly.

Thus, my aim in this study is to explore the legitimation of TCM practices in the THCS as a multidimensional process, which includes dimensions of professionals, multiple legitimacy criteria mobilized by professionals during the legitimation process, and TCM practices being evaluated by professionals. There is recent call to model legitimation by taking into consideration multiple dimensions (Deephouse et al., 2017). However, there seems not to be any study regarding legitimation as a multidimensional process that explores the interactions among various dimensions. By conceptualizing legitimation as multidimensional, I aim to avoid some problems of unidimensionality. In other words, legitimation in a multidimensional model will capture some critical dynamics of the process and thus capture the overall complexity while avoiding potential biases of unidimensionality. Specifically, the results may make it possible to conceptualize how the process of legitimation unfolds between different dimensions of legitimacy.

In order to reach these theoretical aims, I conducted qualitative research among medical professionals in the THCS by using semi-structured interviews. In addition, secondary data sources were used, which provided background information. Data analysis was done using coding procedures that took into consideration pertinent literature and theories. Findings reveal that legitimation of TCM practices in the THCS reveals some professional profiles that constitute an empirical explanation for how legitimation unfolds between legitimated entities (namely TCM practices), multiple legitimacy criteria, and legitimators (namely professionals). The legitimation process is driven by the outcast and heterogeneous nature of the regulated TCM practices; by the professional schism within the THCS, which emerged prior to TCM integration process; and by the multiple legitimacy criteria mobilized by professionals, together with interactions among them. In the end, to capture the overall complexity of any legitimation process, the dimensions should be considered continuously, meaning that legitimacy is not a static outcome of evaluation but rather a continuous and contested process.

This dissertation is organized as follows. In the next chapter, I review the literature on legitimacy to pinpoint the theoretical opportunities that I want to address in this study. In Chapter 3, I review the historical worldwide development of the healthcare profession and the evolution of healthcare systems with regards to TCM practices. In Chapter 4, I introduce

the THCS in an empirical context, providing information about field evolution and TCM-related developments. In Chapter 5, I lay out the methodology, describing sampling, interview procedures, other data sources, and analysis methods. In Chapter 6, I present the findings, which is followed by a discussion of findings in Chapter 7, highlighting contributions to the literature. Finally, I end with a concluding chapter (Chapter 8) that addresses managerial and practical implications, limitations of the study, and suggestions for further future research.

2. LITERATURE REVIEW

2.1. Definitions

Legitimacy, which as a research construct dates back to the studies of Weber (1930) and Parsons (1956), has been at the heart of organizational and management studies (Deephouse et al., 2017; Suddaby et al., 2017). According to Deephouse and Suchman (2008), the year 1995 can be accepted as the pivotal point for the studies of legitimacy since two main conceptual definitions of the term were proposed then. Most researchers have used Suchman's (1995) definition of legitimacy verbatim, which presents legitimacy as the "generalized perception or assumption that the actions of an entity are desirable, proper, or appropriate within some socially constructed system of norms, values, beliefs, and definitions" (p. 574). Within this scope, he delineated two basic views: an institutional view emphasizing how constitutive societal beliefs become embedded in organizations and a strategic view emphasizing how legitimacy can be managed to help achieve organizational goals (Deephouse & Suchman, 2008). Another salient definition of legitimacy was proposed by Scott (1995), which approaches legitimacy as a condition reflecting cultural alignment, normative support, or consonance with relevant rules or laws (p. 72). These definitions provide necessary conceptual tools to study legitimacy as a research construct starting with the dimensions of legitimacy.

Dimensions of legitimacy have been explored through conceptual efforts devoted to identifying key types or categories of legitimacy (Suddaby et al., 2017). According to Suchman (1995), there are three main dimensions of legitimacy, namely pragmatic legitimacy based on the audience's interests, moral legitimacy based on normative approval, and cognitive legitimacy based on comprehensibility and taken-for-grantedness. Similarly, Scott (1995) identified three dimensions of legitimacy as regulative legitimacy, which reflects laws and regulations; normative legitimacy, which is based on moral obligations; and cognitive legitimacy, which rests on preconscious, taken-for-granted understandings. Scott (1995) based these legitimacy dimensions on the three pillars of institutions, namely regulative, normative, and cultural-cognitive pillars. Pillars of institutions represent the elements identified by one social theorist or another as the vital ingredients of institutions (Scott, 1995, p. 59). Therefore, Scott (1995) linked these pillars to the basis of legitimacy, albeit in a different sense.

There has been some effort to revise the dimensions of legitimacy. For example, Archibald (2004) combined normative and cognitive legitimacy in a new category called cultural legitimacy. As cultural legitimacy, Archibald (2004) considered cultural recognition in professional contexts. Similarly, Deephouse and Suchman (2008) criticized the definition of normative legitimacy primarily as professional endorsement and proposed to use professional legitimacy instead. By professional legitimacy, they refer to legitimacy conferred by professional endorsement (on any grounds), whereas normative legitimacy should refer to legitimacy conferred by any audience (including but not limited to professionals) on primarily normative grounds (Deephouse & Suchman, 2008, p. 53). On the other hand, the extant literature relies on DiMaggio and Powell's (1983) view, which accepts normative legitimacy as being in congruence with the particular ethics and worldviews of formal professions (Deephouse & Suchman, 2008).

Apart from the dimensions of legitimacy, the widely accepted definitions provide two alternative conceptualizations of legitimacy: legitimacy as a state and legitimacy as a process. Words such as proper, appropriate, desirable, alignment, consonance, acceptable, and debated or illegitimate have been used to label the states of legitimacy (Deephouse et al., 2017). Deephouse and Suchman (2008) argued that legitimacy is fundamentally dichotomous, meaning that any entity is either legitimate or illegitimate. Most of the institutionalist researchers subscribe to this view (Tost, 2011; Vergne, 2011) or illegitimacy of entities (Oliver, 1992). On the other hand, some researchers have operationalized legitimacy using ordinal or continuous measures (Deephouse et al., 2017), as well. For organizational ecologists (Carroll & Hannan, 1989) it is the density or number of organizations that determines legitimation. Thus, increasing density is the cause or indicator of increase in legitimacy, the assumption of which accepts the possibility of different degrees of legitimacy between high and low legitimacy.

From another perspective, legitimacy has been studied as a process, which has been called legitimation and assumed to be the change in the legitimacy of any entity over time (Ashforth & Gibbs, 1990). Legitimation as a process is commonly studied as a linear and smooth process during which the change in the legitimacy of an entity happens in a sequential form (Greenwood, Suddaby, & Hinings, 2002; Johnson, Dowd, & Ridgeway, 2006). Furthermore, the legitimation of any entity creates contestation among related actors during the process (Greenwood et al., 2002; Vaara, 2014). The change in the legitimacy of any entity may be

in the form of delegitimation, which means establishing the sense of a negative, morally reprehensible, or otherwise unacceptable action or overall state of affairs (Vaara, 2014). In addition, it may be in the form of relegitimation, which is accepted as the restoration of the sense of a positive, beneficial, ethical, understandable, necessary, or otherwise acceptable action in a specific setting (Vaara, 2014).

As a process, legitimation concerns the evaluation of entities as mentioned above. The entities of legitimacy can be organizational forms, structures, decisions, strategies, practices, products, or services. In their examination of big five accounting firms, Suddaby and Greenwood (2005) took into consideration the legitimation of a new organizational form, which was the extension of accounting provisions together with law services by the same firm. In another study, the entity is the contested shutdown decisions of multinational corporations (Vaara & Tienari, 2008). In their study of legitimation of socially responsible mutual funds, Markowitz, Cobb, and Hedley (2012) argued how this new form of product constituted the pertinent entity. Finally, some scholars examine legitimation of practices. For Jarzabkowski (2005), practice refers to activity patterns across actors that are infused with broader meaning and provide tools for ordering social life and activity. Lounsbury and Crumley (2007) defined practice as a kind of institution, with sets of material activities that are fundamentally interpenetrated and shaped by broader cultural frameworks. Therefore, Koreman (2014) studied local music in the Dutch context as the legitimated practice, whereas legitimation of nouvelle cuisine in the French context was studied by Rao, Monin, and Durand (2003), who took into consideration different gastronomical practices as entities of legitimation. As a result, anything in an organizational setting can be studied as a legitimated entity. The practice to legitimated can be a single practice, such as explained by the extant literature, or it may be constituted by a heterogeneous bundle. Bundles of practices may give rise to a hierarchy of legitimacy between different practices, which means that some of them may be already legitimate but others may require time to reach that level of legitimacy.

The process of legitimation includes legitimators, as well. Legitimators are the related stakeholders who make legitimacy evaluations (Deephouse et al., 2017). Legitimators derive from the organizational field, which is a recognized area of institutional life of key suppliers, resource and product consumers, regulatory agencies, and other organizations (Scott, Ruef, Mendel, & Caronna, 2000) and their members. Commonly studied legitimators are the state,

professionals, and diffuse audiences such as experts, consumers, or public opinion as well. State support during legitimation processes was studied by many scholars, such as (Kwiek, 2012), who argued that governmental regulations enabled the legitimation of new teaching policies in the Polish university system and thus delegitimated traditional methods. Some other legitimators might be external experts, such as the securities analysts and investors on Wall Street examined by Navis and Glynn (2010), as well as the mainstream news media, focused on the viability of satellite radio as a new market category.

Other commonly studied legitimators in the legitimation process are professionals. A profession is simply defined as an exclusive occupational group applying somewhat abstract knowledge to particular cases (Abbott, 1988). Occupations that gain jurisdictional control (which means control over provision of specific services) and prove possession of expert knowledge deserve to become a profession and thus professionalize. The term 'professionalization' is used interchangeably with 'legitimation', which confers a degree of change in the construal of a profession. Recently, the term 'professional projects' has been used to refer to the controlling supply of expert labor and the behavior of producers (Muzio, Brock, & Suddaby, 2013). Professionals handle legitimation work in terms of these two dimensions by answering the questions of who are the legitimate practitioners of any profession are and what are included as legitimate practices. From this perspective, professionals have been seen as the setters of normative legitimacy (Ruef & Scott, 1998; Scott, 1995). Normative legitimacy is defined as approbation of any legitimated entity by professionals and their associations (Scott et al., 2000, p. 238). The definition is similar to the moral legitimacy of Suchman (1995), which reflects a positive normative evaluation of the organization and its activities (p. 579).

Professionals confer normative legitimacy through the provision of standards that ensure that certain jobs and positions are reserved for people with appropriate professional credentials (Scott et al., 2000). Professionals and their associations through systems of certification or accreditation provide normative legitimacy to their fields. For example, in the United States, the American Medical Association has been acting as the sole authority of enforcing standards for medical education and practices of physicians (Scott et al., 2000).

Legitimators, including professionals, evaluate legitimated entities against some form of standards during legitimation, which are defined as criteria of legitimation (Deephouse et al., 2017). According to Scott (1995), legitimacy criteria depend on the related institutional

pillars, which depend on the type of the legitimacy, as well. For example, legitimation appealing to moral standards provides moral legitimacy that is based on the normative pillar of the institutions.

Therefore, there are several types of legitimacy criteria and these can be useful for identifying different dimensions of legitimacy. According to Deephouse et al. (2017), there are four basic types of criteria for evaluating legitimacy: regulatory, pragmatic, moral, and cultural-cognitive. Being in accordance with state regulations may ensure regulative legitimacy (Bitektine, 2011; Johnson et al., 2006; Kwiek, 2012; Ruef & Scott, 1998), whereas concurrence with some interests of the related domain may provide pragmatic legitimacy (Bicho, Nikolaeva & Lages, 2013; Suchman, 1995). Ethical or moral judgments are seen as the components of moral legitimacy, such as support for social responsibility projects (Deephouse et al., 2017; O'Neil & Ucbasaran, 2016). Cognitive legitimacy is defined as taken-for-grantedness (Scott, 1995), as mentioned before. Any entity is considered to display cognitive legitimacy when it is considered that it carries out its activities in the best possible way (Cruz-Suarez, Prado-Román, & Prado-Román, 2014). Therefore, cognitive legitimacy is knowledge-based rather than interest-based or judgment-based (Cruz-Suarez et al., 2014). According to the institutionalist view, cognitive legitimacy is related to the diffusion and contagion of any entity thus being taken for granted during the process (Bitektine & Haack, 2015; Scott, 1995), whereas organizational ecologists define cognitive legitimacy in terms of the density dependence as mentioned above (Carroll & Hannan, 1989). Finally, professional endorsement is defined as normative legitimacy (Scott et al., 2000). However, recent studies theorized that professionals appeal to non-professional credentials as legitimacy criteria (Croidieu & Kim, 2018), such as market legitimacy (Bicho et al., 2013; Scott et al., 2000) or competence legitimacy (Sanders & Harrison, 2008). Though there is not a clear definition of market legitimacy, it seems to be a legitimacy criterion that reflects the importance of approval and consonance to several market-oriented mechanisms such as customer choices, competition, sales, prices, and budgetary effects (Bicho et al., 2013; Blomgren & Waks, 2015). Competence legitimacy, on the other hand, is defined as the adequacy of practitioners' personal skills to perform specific professional work (Sanders & Harrison, 2008).

Some legitimation processes require different criteria for legitimacy evaluation, as well. For example, Bansal and Clelland (2004) defined corporate environmental legitimacy as the

generalized perception or assumption that a firm's corporate environmental performance is desirable, proper, or appropriate (p. 94). They assume that corporate environmental legitimacy is related to less variability in a firm's stock price associated with firm-specific events. In another study, Broom and Tovey (2007) find that any medical treatment as a legitimacy entity has to be scientifically legitimate to be applied in healthcare systems. By scientific legitimacy, they assume work being published in the right journals, with an appropriate methodological design, vetted by the right people (Broom & Tovey, 2007, p. 559).

Some scholars rely on legitimacy criteria that reflect more than one institutional pillar and thus combine more than one dimension of legitimacy, as well. Ideological legitimacy or political legitimacy can be assumed from this view. Political legitimacy is defined as conformity to the established rules, justified by the shared beliefs and existence of an ongoing expressed consent by the related authorities (Beetham, 1991). As the definition implies, political legitimacy seems to be a combination of regulative, moral, and normative legitimacy that supports the idea of Scott (1995) whereby each legitimacy criterion depends on institutional pillars. Similarly, ideological legitimacy reflects accordance between ideological orientations of legitimators and the legitimated entity, such as relatively stable belief systems like religion (Dijk, 2006). According to Dijk (2006), ideological legitimacy may function as the basis of the guidelines of professional behavior, as well. The extant literature reveals the existence of multiple legitimacy criteria, which constitute a base for legitimacy evaluations of the legitimators.

The situation of multiple criteria with multiple evaluators of legitimacy has been defined as a 'legitimacy challenge' (Deephouse et al., 2017). During a legitimacy challenge, legitimators may link different legitimacy criteria to each other. For example, performance criteria with normative or moral criteria or a combination of the morals of the entity with its pragmatic legitimacy. According to some studies, existence of multiple legitimacy criteria creates legitimacy contestation. For example, Erkama and Vaara (2010) paid attention to legitimacy contestation during industrial and organizational restructurings such as shutdown decisions. Similarly, Vaara (2014) discussed the discursive underpinnings of the legitimacy contestation that the Eurozone as a transnational institution is facing. Occasionally, legitimacy contestations of these kinds focus on the rhetorical struggles of the actors

(Erkama & Vaara, 2010; Leeuwen Van & Wodak, 1999; Vaara & Monin, 2010; Vaara & Tienari, 2008).

The extant literature focuses on the legitimation of new ventures. For example, O'Neil and Ucbasaran (2016) focus on new venture legitimation by focusing both on how environmental entrepreneurs enact their values and beliefs during the legitimation process and on the resultant business and personal consequences. Similarly, Navis and Glynn (2010) considered how new market categories emerge and are legitimated through a confluence of factors internal to the category (entrepreneurial ventures) and external to the category (interested audiences). There are other examples that explain how innovative ventures become legitimated by the existence of either problematic or strongly established forms in the field, what kinds of strategies are used by the entrepreneurs or by the state or other related actors, and how the process unfolds (Alcantara, Mitsuhashi, & Hoshino, 2006; Aldrich & Fiol, 1994; Clercq & Voronov, 2009; Fisher et al., 2016, 2017; Laïfi & Josserand, 2016; Sine, David, & Mitsuhashi, 2007).

Rarely, the sub-rosa operation of some legitimated entities together with their current revival in the form of relegitimation processes (Dobrev, 2001) has been taken into consideration. Dobrev (2001) considered the evolutionary dynamics of the Bulgarian newspaper industry as it transitioned through multiple political and institutional environments. Thus, the notion of relegitimation is advanced in the context of comparing the cognitive diffusion of the organizational form prior to the Communist takeover in 1946 and its revival in the collective memory of the public after 1989 (Dobrev, 2001).

However, the literature seems silent about the legitimation of an outcast practice as a legitimated entity. An outcast practice can be assumed as an entity that was denigrated by the dominant practices of an organizational field during the establishment of the field and thus lost its ground. However, that entity was not forgotten totally and is being legitimated currently. Such a context may provide contestation over legitimation processes. Below I review the literature on legitimacy and professionals to develop the preliminary framework that guides my empirical investigation. I specifically delve into the legitimating process of an outcast practice, driven by professionals, mobilizing diverse legitimacy criteria and the ensuing contestation.

2.2. Conceptual Framework

The extant literature about legitimacy considered legitimation as a unidimensional process. That is, most of the studies focus on only one aspect of the process: the legitimated entities, the legitimators, or the legitimacy criteria. Moreover, most of the studies overlooked the multiplicity of those aspects and potential interactions among them. On the other hand, conceptualizing legitimation as a multidimensional process that includes legitimated entities, legitimacy criteria, and legitimators together with the interactions among them may provide a theoretical contribution, which I will address in the below sections.

2.2.1. Addressing the Theoretical Gap

The legitimation process is multidimensional, albeit studied as unidimensional in the extant literature. There is a recent call for extending combinations of legitimated entities, legitimators, and legitimacy criteria by examining the legitimation process in evolving institutional fields (Deephouse et al., 2017). Therefore, I assume legitimation as a multidimensional process that is the result of the constellation of and interaction between legitimated entities—namely practices, legitimacy criteria, and legitimators—namely professionals.

Most legitimation studies focus on the legitimation of new practices or innovations as mentioned before. The majority of these studies consider a single practice to be legitimated, such as a new market category (Navis & Glynn, 2010), provision of socially responsible mutual funds (Markowitz et al., 2012), a new digital publishing model (Laïfi & Josserand, 2016), or creation of active money management practice in the US mutual fund industry (Lounsbury & Crumley, 2007). Furthermore, most institutionalist studies consider that new practices become legitimated through mimicry (DiMaggio & Powell, 1983), where established norms and conventions of the field help promote new ones (Delbridge & Edwards, 2008). Greenwood et al. (2002) argue that mimicry of the existing norms of the field enable pragmatic and, in some instances, normative legitimacy for the new practices, thus enabling initial legitimation during the first stages of a change process. Therefore, a practice is accepted as legitimate if it resembles the existing accepted norms of the field. This view is reflected in the concept of categorical legitimacy, which is the degree to which an innovation is perceived as consistent with the existing values, past experiences, and needs of potential adopters (Rossman, 2014). According to this view, innovations can diffuse

rapidly when they are nested within already established categories, thus reaching a density (Rossman, 2014) and gaining social consensus (Greenwood et al., 2002). Thus, legitimacy is seen as the direct function of categorical density (Rossman, 2014, p. 60) and diffusion. Studying the legitimation of a single new practice from a perspective of diffusion or mimicry restricts the dimension to be considered. Legitimation through density dependence ensures cognitive legitimacy (Carroll & Hannan, 1989; Rossman, 2014) or legitimation through consonance with the existing practices ensures pragmatic and moral legitimacy (Greenwood et al., 2002; Ruef & Scott, 1998). Thus, studying a single practice requires appealing to a limited number of legitimacy criteria.

Regarding practices as legitimated entities, there may be some other alternatives such as studying heterogeneous bundles of practices instead of a single practice. However, a bundle may attain dispersed legitimacy criteria to be considered, which may give rise to theorizing legitimation as an interactive process between practices and criteria. Besides, legitimation of outcast practices other than innovations or new practices has not been studied properly.

Another approach to the study of legitimation in the extant literature is focusing on legitimacy criteria as the sole dimension of the process. Some scholars from post-Soviet countries have taken into consideration regulative legitimacy and assume state regulations as the main dimension of the legitimation process (Dobrev, 2001; Kwiek, 2012). Although the state is among the main legitimators in providing regulative legitimacy, this has not been studied properly as a legitimacy criterion in interaction with other criteria.

Apart from these, some studies focus solely on normative legitimacy (Ruef & Scott, 1998). The problem is that most of the normative legitimacy studies assume normative approval as professional endorsement (Deephouse & Suchman, 2008). Deephouse and Suchman (2008) proposed that normative legitimacy includes professionals' approval but is not limited to it. The construct includes broader normative grounds, which are conferred by any other legitimator. Although this approach extends the concept of normative legitimacy, it narrows professional legitimacy by accepting professionals' norms as something standard. Thus, it can be claimed that normative and professional legitimacy criteria have not been studied properly since potential interactions between other dimensions were overlooked.

The extant literature on legitimation considers public prevalence, which is measured by extensive media coverage as an indicator of taken-for-grantedness and thus cognitive

legitimacy (Vaara, 2014; Vaara & Monin, 2010; Vaara & Tienari, 2008; Vaara, Tienari, & Laurila, 2006). The textual analysis of media coverage, which is similar to the counting principle of density dependence, is seen as the main legitimacy criterion for these studies. However, this stream overlooks other legitimacy criteria, which may have an impact on the legitimation process. For example, Joutsenvirta and Vaara (2015) analyzed national public legitimacy struggles around a contested investment project. They took into consideration media texts of the leading newspapers in three countries in their empirical settings, which are leading outlets of public discussion in the respective countries (Joutsenvirta & Vaara, 2015, p. 746). However, there are arguably other legitimators such as governmental agencies or professional associations, which may reveal their evaluations with other indicators such as regulations or accreditations. Thus, focusing on only one legitimacy criterion may lead to missing the overall picture of any legitimation process.

There are arguably some studies that focus on multiple legitimacy criteria, but they are not considering the legitimation as multidimensional. For example, Fisher et al., (2017) examined new technology legitimation by entrepreneurs who rely on different legitimacy criteria depending on the consumers they have to convince. Although the study accepts the existence of multiple criteria, the model they propose is lacking in being multidimensional since the practice to be legitimated (new technology) is a single practice, restricting potential spillover among legitimacy criteria. Besides, entrepreneurs as legitimators are assumed as a homogeneous group without revealing a hierarchy among various legitimacy criteria. In another example, Laïfi and Josserand (2016) found that entities of legitimation are one of the determinants of legitimacy criteria. They provided a theoretical frame for explaining the nonlinear combination of legitimation of new ventures in the digital industry. However, they propose a sequential form of legitimacy criteria selection (Laïfi & Josserand, 2016, p. 2349), which is in accordance with the existing literature (Greenwood et al., 2002; Johnson et al., 2006; Tolbert & Zucker, 1996). Thus, the study fails to provide a multidimensional frame considering the interaction of various legitimacy criteria in the same phase of the legitimation process.

In addition to the practices to be legitimated and the legitimacy criteria appealed to, a legitimation process includes legitimators, as well. Professionals are among the main legitimators accepted by the extant literature, as mentioned before. However, the extant literature approaches professionals as the sources of normative legitimacy (Ruef & Scott,

1998; Scott, 1995). Although there are some recent studies theorizing that professionals appeal to the some legitimacy criteria such as non-professional credentials (Croidieu & Kim, 2018) or market legitimacy, competence legitimacy, or scientific legitimacy (Sanders & Harrison, 2008), the majority of studies that focus on professionals as legitimators approach them as a homogeneous community. With this acceptance of a homogeneous community, scholars approach professionals as not being divided at all. Therefore, a legitimacy contestation among professionals during which multiple legitimacy criteria are evaluated by professionals has not been studied properly. Besides, existing professional schisms in the field may unfold a legitimation process that has not been studied properly as well.

In a few studies, in the case of a legitimacy contestation, professionals are classified as proponents and opponents of the legitimated entity (Creed, Scully, & Austin, 2002; Joutsenvirta & Vaara, 2015; Sanders & Harrison, 2008; Suddaby & Greenwood, 2005; Vaara, 2014; Vaara & Tienari, 2008). However, the possibility of the division of professionals beyond proponents and opponents together with wider legitimacy criteria preferences has not been studied properly in the extant literature. In their long-term study about profound institutional change of the "Big Five" accounting firms, Suddaby and Greenwood (2005) found that proponents of the legitimation considered the market value of the new form of organizing (provision of accounting together with law), thus relying on pragmatic legitimacy (p. 47). Meanwhile, opponents relied on moral and normative legitimacy with their expressions emphasizing differences between auditors and lawyers as professionals (p. 48). The study exemplifies how a new organizational form can divide professionals, which in turn determines their legitimacy criteria choices. However, the potential interaction between legitimacy criteria and professional divisions was not studied from a multidimensional perspective.

Therefore, I propose to study legitimation as a multidimensional process during which legitimated practices, legitimacy criteria, and professionals as legitimators interact, thus creating contested space of legitimation. In the next section, I will explain the potential benefits of this theoretical framework.

2.2.2. Legitimation as a Multidimensional Process

As the literature reviewed up to this point revealed, legitimation is generally studied as a unidimensional process, though there are some exceptions (Fisher et al., 2017; Laïfi &

Josserand, 2016) in extant literature. Studying legitimation as a unidimensional process runs the risk of three conceptual mishaps: (1) potential biases in examination; (2) insufficient attention to critical dynamics of the process, which may lead to ignorance of the overall complexity of the process; and (3) overlooking the continuously problematic nature of legitimation in a multidimensional space.

The first dimension of potential bias is focusing on only the diffusion and adoption of a single practice of legitimation. The majority of the studies of legitimation consider the launch of a new practice, which is legitimized, with the standards of existing practices. Diffusion of newcomers or adoption by the established actors are accepted as indicators of legitimation. In their study of legitimation of human resources practices in Italy, Mazza and Alvarez (2000) counted the increase in the numbers of practices appearing in the press and academic publications to reveal the diffusion of those practices and thus the legitimation of those practices. Although they considered adoption of human resource management by large firms as an indicator of normative approval (Mazza & Alvarez, 2000, p. 579), diffusion as determined by numbers supported the cognitive legitimation of those practices.

According to Carroll and Hannan (1989), density provides a measure for the taken-for-grantedness of any practice in a given field. Therefore, most legitimation studies cover the existence of diffusion or adoption to measure legitimation of new practices (Lounsbury & Crumley, 2007; Navis & Glynn, 2010; Ruef & Scott, 1998). According to Rossman (2014), it is the legitimacy of an accepted category that provides rapid diffusion and accumulation of density to innovations, which makes them legitimated.

Apart from the density dependency perspective, the majority of institutional theorists focus on legitimation of a single practice from cultural cognitive forces in a given field as well (Scott et al., 2000). However, legitimation studies avoid measuring cognitive acceptance and appeal to some other measures, which are used as proxies for legitimation. For example, media coverage is among the favorable indicators appealed to for measuring a field's level taken-for-grantedness (Vaara, 2014; Vaara et al., 2006). Even in their long-term study of institutional change and healthcare organizations Scott et al. (2000) preferred to use density, i.e. numbers of organizations adopting a given form, as an indicator of cognitive legitimacy, as well. Although they used normative legitimacy in the form of professionals' and their associations' support and regulative legitimacy in the form of state regulations, their study accepted professionals as a homogeneous group relying on the standards of the American

Medical Association (Scott et al., 2000). Therefore, they overlooked other legitimacy criteria to be used by professionals.

The problem about focusing on a single practice is that it may create some risks for examining the legitimation process. First, there is the omission of multiple legitimacy criteria and emphasis on one criterion in a majority of the studies. However, multiplicity of legitimacy criteria should be considered together with the practice to be legitimated; thus, not only diffusion and adoption or normative approval but also latent legitimacy criteria that emerge during the process should be considered. Second, even if multiple criteria have been considered (such as in the case of Scott et al., 2000) there is a risk of omitting divisions among potential legitimators such as the state or professionals. That is why legitimators together with the criteria have to be considered to avoid potential bias of legitimizing a single practice, which can be provided by studying legitimation as a multidimensional process.

The second potential bias associated with studying legitimation as unidimensional may result from focusing only on legitimacy criteria. Some legitimation studies consider legitimacy criteria deployed by legitimators while omitting interaction with those legitimators and legitimated practices as well. For example, Sanders and Harrison (2008) identified that professionals appeal to some subdimensions of professional legitimacy, such as competence legitimacy. However, that study does not explain the reasons why those professionals deploy different legitimacy criteria. Thus, focusing solely on the legitimacy criteria extraction from an empirical setting limits the possibility to conceptualize the legitimation process. In another study, Bansal and Clelland (2004) observed that firms earn environmental legitimacy when their performance with respect to the natural environment conforms to stakeholders' expectations. The study measures the value of the firm (in terms of stock prices) with respect to environmental legitimacy. However, stakeholders' grounds of stock preference may depend on other criteria as well, and thus the study ignores the possibility of other legitimacy criteria in relation with legitimators.

The final potential bias related to studying legitimation as a unidimensional process may result from focusing only on legitimators, namely professionals. The main bias of studying professionals results from two points. The first is the general acceptance of professionals as an undivided community in which each member shares the same normative and cultural cognitive acceptances. The second is the general tendency to see professionals as providers of normative legitimacy. Scott et al. (2000) defined normative legitimacy as the endorsement

of professionals and their associations. The existence of normative legitimacy was measured in terms of hospitals' accreditation or membership in the national or local professional associations. Ruef and Scott (1998) assume that, for hospitals, normative assessments by industrywide professional associations have more salience than do regulative or cognitive assessments (p. 882). Accordingly, they accept that for some practices (such as healthcare provision by hospitals), one legitimacy criterion may be more important for legitimators. However, they neglect the possibility of combining multiple legitimacy criteria for more practices during the same legitimation process.

There are some exceptional studies that accept the appeal to other legitimacy criteria by professionals, such as cognitive or regulative legitimacy by building relational legitimacy through external networks (Daudigeos, 2013). However, the extant literature assumes professionals as a unified group providing normative legitimacy. On the other hand, legitimation as a multidimensional process may provide some room to explain how professionals deploy multiple legitimacy criteria for multiple practices.

Another risk of legitimation as a unidimensional process may be improper examination of critical dynamics of the process, which may lead to ignorance of the overall complexity of the process. By critical dynamics, the interactions among dimensions of legitimation are inferred. For example, there may be some interactions among a practice to be legitimated and legitimacy criteria. If the legitimated entity is a single practice, such as in the case of innovation or new venture legitimations, such an interaction may be not important. However, in the case of a bundle legitimation, which means legitimating more practices in the same bundle, albeit not homogeneous ones, there is risk of spillover of legitimacy criteria. One criterion that legitimizes one practice may be meaningless or may not be applicable for another. Such theorizations of the legitimacy criteria in interaction with the practices may influence the overall legitimation of the bundle. Another potential interaction may be between professionals and legitimacy criteria, as well.

Finally, studying legitimation as a unidimensional process may lead to ignoring the potential problematic nature (Ashforth & Gibbs, 1990) of the process. Legitimation is not decided once and for all; instead, legitimation is a process unfolding in a multidimensional space made up of professionals, practices, and legitimacy criteria, which is interactively evolving with the interactions among them. Commonly, legitimation studies approach the results of evaluation creating a dichotomous judgment, either legitimate or illegitimate (Deephouse et

al., 2017). However, it may not be possible to reach such a consequence as a result of some legitimation processes.

There are a few studies that focused on legitimation as a multidimensional process (Fisher et al., 2017; Laïfi & Josserand, 2016; Ruef & Scott, 1998; Sanders & Harrison, 2008). Ruef and Scott (1998) emphasized that multidimensional models of legitimacy offer both theoretical and empirical benefits to organizational and more broadly social scientific inquiry (p. 898). Thus, they encourage the development of such models. However, they focused on normative legitimacy—albeit managerial and technological dimensions of it—in their study and thus neglected other legitimacy criteria (Ruef & Scott, 1998). Until recently, the literature seems silent about their call.

Recently Fisher et al. (2017) studied how entrepreneurs manage new venture legitimacy evaluations across diverse actors, so as to appear legitimate to the different groups that provide much needed financial resources for venture survival and growth. The study focused on the venture legitimation process, which is in accordance with the extant literature. Entrepreneurs are accepted as the legitimators. They are the main actors who are trying to convince various stakeholders of the organization, such as government agencies, angel investors, or corporate venture capitalists (Fisher et al., 2017, p. 57). The study accepted the existence of contrasting legitimacy criteria if new ventures are to be perceived as legitimate by various stakeholders. Although the multiplicity of legitimacy criteria and legitimators were accepted, the study failed to explain potential divisions among legitimator groups. For example, government agencies seek the regulative legitimacy dimension of the legitimated new technology, whereas angel investors, who use their own funds to provide seed capital to new technology ventures, rely on the market legitimacy of the investment for their personal interest. This thus combines pragmatic legitimacy and the market legitimacy. On the other hand, corporate venture capitalists, who invest in new ventures on behalf of corporations, rely on the market benefits together with the moral standards of the corporation, thus, combining market legitimacy with moral legitimacy. Thus, they assume that each stakeholder group is homogeneous among itself, and different from the other groups, relying on similar legitimacy evaluation. The authors accept that the purity of the proposed typology will obviously be violated the first time someone does empirical research on it (p. 68). They propose that many corporate venture capitalists may also make angel investments in their personal capacity; therefore, they bridge the market and professional

legitimacy of angel investing and venture capital. Thus, the authors encourage the study of legitimation as a process that may require observing the same legitimator group as divided. Furthermore, the practice to be legitimated is a single new technology, which has constant standards to be fulfilled for each stakeholder. However, we still know very little about how the process will unfold if the legitimacy practices constitute a heterogeneous bundle and how the process will unfold if it is driven by divided professionals.

In another recent study, legitimation was studied as a multidimensional process, which proposed different legitimacy criteria deployed for a new innovation during different periods of the process (Laïfi & Josserand, 2016). According to this study, for the legitimated practice (a digital library service, in this case), the context of legitimation (the field in which the innovation was launched as a product) and key actors such as clients or publishers determine the legitimacy criteria to be deployed in different time periods. The main contribution of the study is considering multiple dimensions of legitimation and extending a linear sequential form of the legitimation process (p. 2350). However, the study, in accepting a new single practice, overlooked the capture of potential spillover among different legitimacy criteria deployed by the entrepreneurs. Thus, while there is acceptance of the possibility of division among key actors (p. 2349), it is not properly explained how these groups employ different legitimacy criteria at the same time (instead of over years, as was studied in this article).

Moreover, albeit proposing a multidimensional process of legitimation, the studies of Laïfi and Josserand (2016) and Fisher et al., (2017) consider the launch of a new practice. Therefore, there are actors who are entrepreneurs, who try to legitimize the practice, and other stakeholder actors who evaluate the entrepreneurs' legitimizing efforts. Therefore, even though the authors accept the multiplicity of legitimacy criteria in both studies, they fail to explain any potential contestation within the same group resulting from that multiplicity. Besides, the actors, either entrepreneurs or the others, are accepted as a single group that relies on similar legitimacy evaluations. The possible schisms among legitimator actors have been overlooked. Apart from these points, these studies consider a new venture or innovation. However, the legitimation of a practice that fell into an outcast position during the establishment of an organizational field may unfold with interactions between that practice and actors, as well. Furthermore, if the legitimated entity is a bundle of practices, each of which requires different criteria, there is the possibility of interaction among practices, as well.

Therefore, in the conceptual framework that I propose in this dissertation, I assume that the legitimation process may include dimensions of bundles of practices that were outcast, and that there is multiplicity of legitimacy criteria and professional division unfolding the legitimation process. The evolving interaction among these dimensions may make the legitimation process problematic in nature.

In the next chapter, I begin to explain the empirical setting that may give rise to such theorization of the legitimation process as a multidimensional process.

3. CHANGE IN HEALTHCARE SYSTEMS

In this chapter, I first explain how modern medicine became the dominant paradigm providing the main legitimacy criteria for healing people, although it has lost power recently. I then summarize how TCM created legitimacy contestations in addition to the existing divisions in modern medicine. Legitimacy contestations in the TCM field including multiple legitimacy criteria of TCM practices together with global works addressing the evaluation of legitimacy of TCM practices are included. Professional contestations regarding the legitimacy of TCM practices and several countries' experiences of legitimacy contestations of TCM are explained at the end of the chapter.

3.1. How Modern Medicine Became a Dominant Paradigm

Medicine has a long history, be it mainstream modern medicine or various ancient forms. The discipline is full of fragmentation not only resulting from attitudes towards healing, diseases, and patients but also from geographical, cultural, political, religious, and in some areas even sexual differences. There are many debates in the discipline. For example, one involves names: is it mainstream medicine, modern medicine, scientific medicine, orthodox medicine, or biomedicine? Is it western or non-western? Did the flow of medical knowledge occur from west to east or from east to west? Medicine seems to be not only a body of theoretical knowledge or a methodological practice but also a framework within which social, economic, and political practices are articulated (Ebrahimnejad, 2008).

I prefer to apply the name 'modern medicine' to the conventional medicine applied in the majority of healthcare systems and taught in medical schools, which is rooted in a scientific and positivist paradigm. In this thesis, I will refer to all approaches other than TCM practices as 'modern medicine'.[2]

The majority of medicine historians agree that modern medicine emerged and developed primarily in the western world; this process gained momentum after the Enlightenment period, especially during the 18th century (Bayat, 2010; Çelik, 2013; Ebrahimnejad, 2008; Goldstein, 2002). The main characteristics of this and the following centuries were increasing trust in science from a positivist point of view, which encompassed reductionist,

[2] See Appendix A for the dispute over these terms.

determinist, and objectivist research in almost all areas of knowledge, including medicine (Coulter, 2003). However, it was the general acceptance of the germ theory of diseases that led to a radical paradigm shift in medicine (Bayat, 2010; Coulter, 2003; Ebrahimnejad, 2008). According to this approach, microorganisms cause diseases. With this shift, the theory of spontaneous generation, which refers to processes in which different types of life might repeatedly emerge from specific sources other than seeds, eggs, or parents and which dominated medical knowledge for about 2000 years, collapsed (Bayat, 2010). The human body also started to be methodically studied in laboratories (Bayat, 2010). Through an analysis of the parts, defective parts of a malfunctioning organism can be identified and either repaired or replaced via transplants, drugs, engineered genes, etc. (Carleton, 2005). According to some, this theoretical shift was also related to the start of positivist dominance, leading to a mind-body distinction inspired by Cartesian dualism (Goldstein, 2002; Mizrachi et al., 2005).

The rise of modern medicine ignited the exclusion of non-modern practices, which was noticeable as early as the mid-19th century (Ebrahimnejad, 2008; Saks, 2005). In the first half of the 19th century, lobbies targeting the creation of a unified medical profession, establishing modern medicine on a formal and national basis, gained strength. Medicine has been accepted as the most powerful occupational group in terms of achieving professional autonomy since the 19th century (Brosnan, 2015). According to Freidson (1988), there is a link between the reliability and standardized knowledge of modern medicine and the public trust and legitimacy that it deserves. Standardized knowledge became the dominant criterion in evaluating medical knowledge and thus the criterion of legitimacy (Mizrachi, 2002). According to Mizrachi (2002), a medical journal must gain legitimacy within the boundaries of modern medicine even if it has epistemological roots in areas other than science. The ability to visualize ‘disease’ and to quantify it became the standard for any scientific inquiry in medicine (Mizrachi, 2002).

The extant literature accepts that to gain legitimacy in the healthcare field all entities need to play the game according to the rules of modern medicine. To exemplify, Foley and Faircloth (2003) explained the usage of the discourse of modern medicine in the legitimation of midwifery in the US healthcare system.

Technological advancements such as the invention of the microscope or improvements in chemistry such as the production of synthetic drugs in laboratories enhanced the professional

power of modern medicine, as well. Indeed, these events increased the market power of modern medical practitioners creating an industry of healthcare.

The mainstream literature determined that there are four main ways to attain legitimacy for medical treatments (Adams, 2007; Cant & Sharma, 1996):

(1) Clinical legitimacy, as measured by patient use;

(2) Scientific legitimacy, if commensurable with science;

(3) Educational legitimacy, if there is a standardized training system;

(4) Political legitimacy, if approved by the state.

In time, it became apparent how to evaluate any medical treatment, modern medicine and its scientific paradigm became the main criterion for legitimacy. At the same time, the second half of the 20th century witnessed some waves in medicine threatening the strength of modern medicine.

The distinction between 'disease' and 'illness', which is accepted as a common epistemological divide in medical sociology (Mizrachi et al., 2005), has captured attention. Disease refers to an objective, physical, visible, and universal subject, whereas illness refers to the subjective experience of the suffering individual (Mizrachi et al., 2005). Considering the difference between objective and subjective evaluations of patients led to the inclusion of mind-body phenomena (Carleton, 2005) in treatment, which is represented by some TCM practices.

The decline of overall trust in modern medicine for reasons such as failure in treating diabetics, blood pressure, or some cancers, as well as political and economic reasons such as the role of governments, support from other social movements, rise of big businesses, and role of media, has led healthcare systems to evolve around substitutes such as TCM practices (Goldstein, 2002; Mizrachi et al., 2005). This could be because people do not have enough access to modern healthcare, become dissatisfied with the results of chemicals, try to avoid being passive about their own health, or do not want to lose control over their bodies (Çetin, 2007). In some studies, the reason for usage of TCM is seen as a kind of resistance to the authority of modernity (O'Callaghan & Jordan, 2003). This postmodernist view towards medicine is inspired by the homogenization of societies through globalization, which led to

inclusion of previously excluded subcultures via challenges to organizations and professions established by modernity (Eastwood, 2003).

On the other hand, TCM practices (and practitioners as well) face a huge amount of legitimacy contestation in almost every context. Therefore, TCM practices, offered as a solution to some problems in modern medicine, lead to legitimacy contestation in healthcare systems. The main problem area of TCM practices' legitimacy is rooted in definitions of the terms.

3.2. Definitions of Traditional and Complementary Medicine

TCM consolidates a wide variety of healing methods and I will begin this section with broad definitions of the relevant terms. The World Health Organization (WHO) defined the terms as follows (WHO, 2014):

Traditional medicine (TM): Traditional medicine has a long history. It is the sum total of knowledge, skill, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement, or treatment of physical and mental illness.

Complementary medicine (CM): The terms 'complementary medicine' or 'alternative medicine' refer to a broad set of healthcare practices that are not part of a country's own traditional or conventional medicine and are not fully integrated into the dominant healthcare system. They are used interchangeably with traditional medicine in some countries.

Traditional and complementary medicine (TCM): TCM merges TM and CM, encompassing products, practices, and practitioners.

As these definitions show, complementary medicine is different from traditional medicine since there is no specific characteristic assigned to it other than being outside of the dominant system. However, traditional medicine represents an embeddedness in local cultures, beliefs, and indigenous theories of health. Traditional medicine can be seen as authentic and even mystic with the phrase 'whether explicable or not' specifying the difficulty of its evaluation. Although there are such differences between TM and CM, most studies, regulators, and credentials have used them interchangeably as mentioned. Thus, forming a bundle of TCM including diverse practices and practitioners represents a bundle of legitimated entity instead of a single practice by definition at the beginning.

The ideological roots of TCM practices have a longer history than modern medicine but here I want to conceptualize the three most influential theories, namely traditional Chinese medicine, Ayurveda, and humoral pathology theory, as the main ideological sources of TCM since they provide a basis for most TCM practices.

Traditional Chinese medicine is a healing system that dates back more than 2,000 years, based on the idea that disease results from disruption in the flow of vital energy, or qi, in the body and the flow of qi is maintained by keeping a balance in the two forces known as ying and yang[3] (Sutton, 2010).

Ayurveda[4] is an Indian healing system that accepts that prevention and healing of any disease depend on the balance among the body, spirit, and mind of the person (Spencer, 2003). Balance of this kind reflects harmony between the physical, mental, and psychological health of that person.

Humoral pathology theory is an ancient theory that originated from ancient Greek philosophers and was developed as a medical theory by Hippocrates (Bayat, 2010). The theory suggests that disorders in the fluids of the body ('humor' meaning fluids of the body), and especially blood, are the basic factors of disease and also accepts that basic four elements of the earth (water, air, earth, fire) are closely related to characters of people together with their birth dates and geographical locations (Bayat, 2010). The emergence of any disease is the result of disorder between body fluids (Bayat, 2010).

These three approaches commonly assume that balance within the body is a source of both prevention and healing of any disease and illness resulting from disturbances to the human body (Sutton, 2010) or from imbalances within the system (Carroll, 2007; Spencer, 2003). The patient is central to them, not the disease (Carroll, 2007). The human body is considered as a self-regulating system and all parts of it are understood to be interrelated, with the body having the ability to heal itself (Carroll, 2007; Sutton, 2010). These approaches to medicine were shared by Hippocrates as well, who recognized spiritual aspects of healing and

[3] Ying yang theory is guided by the complementarity of opposites (Crumley, 2012). It contains the idea of seeking balance and harmony in everything.

[4] The term 'Ayurveda' combines the Sanskrit words ayur (life) and veda (science or knowledge) according to the National Center for Complementary and Integrative Health.

advanced humoral pathology theory (Carroll, 2007; Ramchandani, Dousti, Barkhordarian, & Chiapelli, 2012), and these were shared by Ibn Sina (*Avicenna*), as well (Bayat, 2010).

I present a summary of some aspects of TCM practices in comparison with modern medicine in Table 1.

Table 1 Summary of Differences between Modern Medicine and TCM

Dimension	**TCM**	**Modern Medicine**
Approach toward study of human body	Holistic Interrelated parts	Partial Laboratory-based
Healing/treatment	Body healing itself, balance	Chemicals, drugs, machine usage
Disease	Results from imbalance within human body	Results from independent factors like virus
Approach towards religion	Some practices rooted in native religions	Excludes religious knowledge from the discipline
Paradigm	Traditional Chinese medicine Ayurveda Humoral pathology theory	Germ theory of disease

3.3. Legitimacy Contestations in the TCM Field

As the definitions above indicate, not all TCM practices possess the same characteristics, at least not to the same degree. The objective and expected outcome of practices may determine how they are evaluated individually.

For example, for homeopathy (see the definition in Appendix A), the choice of a remedy[5] is dependent on the art of prescribing which means you can only fit the right remedy to the right person, if you understand people and cannot be taught by a formula (Cant & Sharma, 1996). This characteristic of the practice is seen as a problem in terms of scientific acceptance but it provides the ultimate source of originality for homeopathy (Cant & Sharma, 1996).

Therefore, it can be inferred that modern medicine and some TCM practices are so incommensurable that any legitimacy criteria that form the main power of one practice may constitute a reason for illegitimacy according to the other's paradigm. Indeed, this diversity

[5] For homeopathy, the TCM literature uses the word 'remedy' instead of 'drug' or 'medicine', which reflects the specific and unique preparation of the homeopathic product mixture. Therefore, I prefer to use 'remedy' as well.

may exist between different TCM practices, as well. Therefore, actual differences occur at the practice level and the legitimacy evaluation of individual practices requires different criteria. There are some alternative legitimacy criteria proposed by different scholars, which will be explained in the next section.

3.3.1. Multiple Legitimacy Criteria for TCM Evaluation

The heterogeneity of TCM practices constitutes the main problem area for legitimacy evaluation of those practices.

One of the alternative legitimacy criteria for TCM practices is evidence-based medicine (EBM). EBM is defined as a clear refinement of the grounds for scientific legitimacy, addressing the extent to which theories and treatments used in practice in healing can be supported by evidence according to the standards of science (Willis & White, 2005). Accordingly, there are some levels of evidence that medical practices should meet in order to be applied, which form a kind of hierarchy. For example, Level I Evidence is obtained from a systematic review of all relevant randomized controlled trials (RCTs)[6], while Level III Evidence is obtained from well-designed cohort or case-control analytic studies, preferably from more than one center or research group, and Level IV constitutes opinions of respected authorities based on clinical experience, descriptive studies, or reports of expert committees (Willis & White, 2005) (see Appendix B for the full hierarchy of evidence according to this classification). As such, the biomedical hierarchy of evidence provides a central conceptual framework for understanding the dynamics of TCM integration (Broom & Tovey, 2007).

However, there is dispute over compelling scientific evidence for modern medicine as well. It has been estimated that only about 15% of modern medical practices are supported by solid scientific evidence (Jackson & Scambler, 2007). Therefore, EBM as a criterion has been criticized by some authors. Besides, there are problems such as questionable quality of studies and translation of data clinically to actual patients (Jackson & Scambler, 2007). Apart

[6] In an RCT, patients with a particular condition are allocated to two or three groups. One group receives the active or new treatment while the second group receives no treatment or a standard treatment. The third group may have an apparently similar but inactive (placebo) treatment. The results or outcomes from all three groups are compared after a predetermined period.

from these points, compliance of scientific evidence conflicts with the core philosophy of some TCM practices such as homeopathy (Cant & Sharma, 1996) and conflicts with paradigms such as patient-centered healthcare or patient involvement in healthcare decisions (Jackson & Scambler, 2007).

Although RCTs are accepted as the current gold standard of research methodology (Jackson & Scambler, 2007), there are some TCM practices such as acupuncture that face difficulty in measuring placebo effect because acupuncture requires the application of needles in both groups and thus a bodily reaction is inevitable in any case (Karatay, 2014).

On the other hand, there are some legitimacy criteria other than scientific evidence in evaluating treatment methods. For example, politico-legal legitimacy reflects the legislative protection of occupational territory by statutory registration, fees from various payment organizations including national state-funded health insurance schemes (where these exist), and practitioners being trained within the state-supported higher education system. Clinical legitimacy, meanwhile, reflects continuing patronage of practitioners by consumers willing to pay for their services (Willis & White, 2005). These are accepted as legitimacy criteria for evaluating medical treatments (and TCM practices, as well) in different contexts.

Specifically, Spencer (2003) provided a summary of criteria for evaluating the legitimacy of TCM practices. In this classification, the categories of Experimental, Clinical (Practice), Safety, Comparative Summary, Rationale, Demand, Satisfaction, Cost, and Meaning are used as evidence in evaluating TCM practices. In this way, the satisfaction and demand of the patients (Do consumers and practitioners want the practice? Is the practice meeting patient and practitioner expectations?) or the meanings assigned to a practice (Is the practice the appropriate therapy for the individual?) are accepted as legitimacy criteria for evaluation of TCM practices.

For TCM practices, the difficulty of evaluation constitutes the main obstacle for its integration into healthcare systems, as mentioned before. It is the main reason for contestation among professionals, as well. There are multiple legitimacy criteria proposed by scholars (Cant & Sharma, 1996; Jackson & Scambler, 2007; Spencer, 2003; Willis & White, 2005). The hierarchical and nature of TCM practices in terms of their acceptability is also mentioned (Broom & Tovey, 2007; Willis & White, 2005). Global health authorities

have also taken some actions regarding TCM legitimacy by means of local projects and reports, which will be explained next.

3.3.2. Worldwide Works on the Legitimacy of TCM

In this subsection, I will mention important reports and releases of global health authorities regarding TCM legitimacy. Those authorities are the WHO, CAMbrella, and UNESCO.

3.3.2.1. The WHO and TCM

The WHO published its first report about TCM in 1978, entitled "The Promotion and Development of Traditional Medicine" (WHO, 1978). This initial report included country examples of practices, integration with modern medicine, and research obstacles. The report ended with recommendations for the development of national policies, educational programs, and research. The most recent relevant WHO publication was released in 2014: 'WHO Traditional Medicine Strategy 2014-2023'. The title includes only the term 'traditional', whereas the content has a wider scope. For instance, the report includes definition of complementary medicine as well (WHO, 2014, p.15). Besides, all of the headings and explanations of the report includes the generic term of Traditional and complementary medicine (T&CM) throughout the report. The most distinguishing aspect of the report is its acceptance of evaluation methods other than RCTs being valuable. It is found acceptable to take advantage of real-life experiments and different research designs and methods in evaluation. Member states are encouraged to develop research methodologies consistent with theories of TCM (WHO, 2014). The WHO calls on member states to regulate TCM practices in their local contexts. According to the report, the number of member states regulating TCM increased from 25 to 69 between 1999 and 2012. Among the regulating countries, half declared regulations for TCM practitioners, as well. Regarding the difficulties faced during regulation, member states declared 'lack of research data' as the main problem. Sixty-five of the countries also stated a great need for technical guidance for research and methodology. These results indicate the necessity to develop appropriate research designs for evaluating TCM practices and thus regulating them.

Between the report of 1978 and the strategic plan in 2014, the WHO published several other reports that address legitimation issues, such as 'General Guidelines for Methodologies on Research and Evaluation of Traditional Medicine' (WHO, 2000). Table 2 summarizes WHO reports about TCM and their contents.

Table 2 WHO Reports Regarding TCM

Date	Title of the report	Content
1985	The Selection and Use of Traditional Remedies in Primary Healthcare	Alerting countries to the importance of testing traditional remedies
1985	The Role of Traditional Medicine in Primary Healthcare in China	Chinese example of research, training, and integration of TCM Comparison with other countries
1989	WHO/Danida Intercountry Course on the Appropriate Methodology for the Selection and Use of Traditional Remedies in National Healthcare Programs	WHO's call to member states to utilize 'safe' and 'effective' traditional practices and remedies
1995	Traditional Practitioners as Primary Healthcare Workers	Report on projects conducted in Ghana, Mexico and Bangladesh that included traditional practitioners Criteria established to determine how these practitioners influenced the healthcare programs
1995	Report of the Third Meeting of Directors of WHO Collaborating Centers for Traditional Medicine	WHO activities in traditional medicine in different regions of the world
1998	Regulatory Situation of Herbal Medicines: A Worldwide Review	Regulation information from 49 member states included
2000	General Guidelines for Methodologies on Research and Evaluation of Traditional Medicine	Recommendations on the evaluation of safety and efficacy of herbal medicines and traditional practices Recommendations on clinical research with provision of design alternatives Ethical issues
2000	Report of the Inter-Regional Workshop on Intellectual Property Rights in the Context of Traditional Medicine	Need to protect traditional knowledge and biodiversity Regulative needs Country examples
2001	Legal Status of Traditional Medicine and Complementary/Alternative Medicine: A Worldwide Review	Information from 123 member states about history of local TCM, regulatory situation, and education and training
2002	Traditional Medicine -Growing Needs and Potential	Brief summary of 2002-2005 traditional medicine strategy

		Recommendations for policy makers
2004	Guidelines on Developing Consumer Information on Proper Use of Traditional, Complementary and Alternative Medicine	Report provided information for the users of TCM to make them active participants in healthcare
2005	Report of a WHO Global Survey over National Policy on Traditional Medicine and Regulation of Herbal Medicines	Information from 141 countries included Assessments of safety and efficacy defined as main challenges
2005	WHO Global Atlas of Traditional, Complementary and Alternative Medicine	Generic maps of countries in terms of TCM regulations, education, public financing
2007	Report of WHO Interregional Workshop on the Use of Traditional Medicine in Primary Healthcare	Country presentations Quality standards

As the reports indicate, the WHO actively guides member states for the regulation of TCM. There is also concern regarding appropriate evaluation methods. The WHO reports provide legitimacy criteria of TCM practices as well by indicating the uniqueness of some TCM practices. However, those reports do not provide any suggestions to member states about how to solve possible legitimacy contestations in local contexts. The number of possible legitimacy criteria increases as years pass, but mechanisms for combining those criteria are not explained to enable member states' regulative actions.

There are some other local but influential reports on TCM research, which will be explained next.

3.3.2.2. CAMbrella

CAMbrella is a pan-European research network for complementary and alternative medicine (Reiter et al., 2012). Its reports summarize the results of project-based research held in European countries on TCM-related issues such as citizens' attitudes about and needs for TCM, country regulations, legal status of stakeholders, prevalence of education, public financing, and usage. There are also provisions for strategies for future networking and dissemination of knowledge. In the context of the present thesis, the importance of these reports derives from the diverse information provided about countries and practices (including herbal medicines as well). The absence of standardization of the regulation of TCM practices also becomes apparent in these reports. For example, they provide the

regulative and reimbursement status of 14 practices initially and the general TCM policies of 39 countries separately. The regulations, reimbursements, and education change dramatically between countries. A practice that is regulated and financed in one country may be unknown in another. Therefore, there are no standards or homogeneity across countries, even though the reports specifically focus on the European region. See Appendix C for some sample maps prepared by CAMbrella, which indicate the heterogeneity of TCM diffusion, integration, and education in Europe.

3.3.2.3. UNESCO and TCM

UNESCO's International Bioethics Committee included the subject of traditional medicine in its work program for 2010-2011. A working group was set up and asked to consider the ethical implications of these widespread and highly varied practices (UNESCO, 2013).

In this report, integration of TCM into national healthcare systems was described on a state-based classification. According to this classification, countries may fall at different points along a spectrum between the extremes of 'Integrated' and 'Prohibited'. Depending on the level of usage, related regulative permissions for TCM may be recognized and integrated into the healthcare system, recognized but not an integral part of the healthcare system (included), or tolerated, leading to a sort of 'laissez-faire' approach and leaving them to develop outside the control of the state. The final form is exclusive prohibition and exclusion of TCM practices. The classification also reflects the fact that TCM varies significantly across countries depending on contextual factors.

There are multiplicity of legitimacy criteria for TCM and related legitimacy contestations in healthcare fields. However, the extant literature about professional legitimacy claims explains non-medical TCM practitioners' efforts to become a legitimate profession by appealing to several of the legitimacy criteria explained above. The next section will describe these studies.

3.4. Professional Divisions Regarding TCM Practices

In an effort to become a profession, TCM practitioners appeal to some legitimacy criteria, as mentioned before. There are some main strategies used by TCM practitioners to professionalize, such as appealing to science (Norris, 2001), improving educational standards, improving practice standards, engaging in peer-reviewed research, and increasing group cohesion (Welsh, Kelner, Wellman, & Boon, 2004). However, sometimes they

emphasize distinctiveness and the keeping of authenticity via emphasizing limitations over holism[7] and prevention such as stressing that others are limited because they cannot do what TCM practitioners do (Norris, 2001). However, seeking external validation for their knowledge claims and accreditation of educational programs remain the main legitimation strategies (Welsh et al., 2004).

The extant literature appeals to the legitimacy of TCM professions from the perspective of boundary work which means professions seek to secure their autonomous position, gain legitimacy, mark and defend their turf, and expand their jurisdiction (Mizrachi et al., 2005). For example, integration of TCM for English cancer patients led to the usage of different rhetorical and practical strategies by medical staff with different positions, which in turn led to professional boundary disputes (Broom & Tovey, 2007). In some settings, boundary demarcation between modern medicine practitioners and TCM practitioners leads to exclusion and marginalization of the modern medicine practitioners (Mizrachi et al., 2005). Legitimacy claims among TCM practitioners and modern medicine practitioners occasionally focus on the relation between systematic knowledge and the legitimacy of a treatment (Hirschkorn, 2006), where universities are proposed as legitimate knowledge providers for both sides (Brosnan, 2015).

Integration of TCM into healthcare systems is explained as a narrative of professionalization of TCM practitioners by some scholars (Broom & Tovey, 2007; Brosnan, 2015; Cant & Sharma, 1996; Hirschkorn, 2006; Mizrachi et al., 2005). Thus, it is explained as a contestation between modern medicine practitioners (doctors) and TCM practitioners. In limited studies, this contestation among medical professionals was explained from a boundary work perspective (Broom & Tovey, 2007).

However, another division may arise among modern medicine doctors themselves. Having graduated from medical schools and having been accepted as the legitimate professionals for healing people, they may fall into disputes over the legitimacy of the methods they use in healing people. Is it legitimate to treat people with any of the TCM practices? The literature

[7] 'Holism' refers to the evaluation of the human body physically and mentally at the same time. 'Prevention' refers to preventing diseases before they happen to avoid medical treatment.

seems silent about explaining such a contestation and division among medical professionals, as mentioned before.

Contextual experiences of different countries also reveal divisions among medical professionals regarding the legitimacy criteria of TCM practices and inclusion of the TCM bundle. The next subsection will explain those issues.

3.4.1. Some Country Examples of Legitimacy Contestations and Professional Contestations of TCM Integration into Healthcare Systems

Countries vary in terms of their approaches to TCM. These approaches may be for or against TCM as a whole, or some practices or some practitioner groups.

Starting with the United States, the Flexner report, which was written by Abraham Flexner in 1910, is an important milestone (Flexner, 1910). The report included a call for American medical schools, which required the enacting of some standards, to strictly obey the protocols of mainstream science in their teaching and research. It was so influential that a kind of standardization of medical schools followed, towards more modern medicine-based training. Thus, it led to a decrease in the teaching of anything other than scientific medicine. The logic behind the criteria proposed in the report centered on giving more credit to medical schools offering science-based medical training and research, such as laboratory experiments. As a result of the report and the responses it received in medical schools in the US, most schools removed TCM practices from their medical training in the years after 1910. Although advocates of some TCM practices, especially osteopaths (see Appendix D for a description of osteopathy) resisted the closure of their platforms in medical schools, results were not in favor of TCM (WHO, 2001).

It is not until the studies of Eisenberg and his colleagues that US society and the government as well again began to pay the necessary attention to the TCM practices that had survived in the country. In their work (Eisenberg et al., 1993), conducted with US citizens via phone interviews, they realized a previously unnoticed large demand for what they called ‘unconventional medicine’. In a further study (Eisenberg et al., 1998), they expanded their research based upon the significant attention that the first article had captured. The same year, the National Center for Complementary and Alternative Medicine[8] was established in

the US with a budget of 19.5 million dollars in recognition of the widespread public use of various forms of TCM. The last study of (Eisenberg et al., 2002) was meaningful with its title of "Credentialing Complementary and Alternative Medicine Providers", as this title reflects both the rhetorical change that occurred over the years from 'unconventional medicine' to 'complementary and alternative medicine' and also the recent concern of regulating 'providers' in those years. According to a WHO report (2001), there is no legitimacy contestation among health professionals regarding the legitimacy of TCM practices and currently the US has state-based regulative acceptance for TCM practices and practitioners as well (WHO, 2001). For example, there is a licensing board for homeopathy in Arizona, Connecticut, and Nevada, but the same system exists for acupuncture in almost every state (WHO, 2001).

There are some other regulations in different parts of the world as well. For example, Germany issued its 'heilpraktiker'[9] regulation in 1939, and by the same year, Japan took into consideration the resurgence of public interest in 'kampo'[10] medicine (WHO, 2001). Before then, the Japanese educational system had been under the influence of the German style of medical training and kampo was excluded from the Japanese healthcare system (WHO, 2002). The difference here is that heilpraktikers are non-medical professionals who have their own association and thus deserve public legitimacy, whereas kampo as a practice was allowed to be applied by medical doctors only and was accepted as archaic by some medical professionals in Japan (WHO, 2001).

[8] The name of the center was changed to National Center for Complementary and Integrative Health for budgetary reasons.

[9] 'Heilpraktiker' (health practitioner) is the common name for TCM practitioners in Germany who have professional associations. Originally introduced in 1939, it licenses practitioners who are not members of recognised health professions to practise provided they have passed an examination in basic medical knowledge and are registered. The system is administered by the Lander (provincial governments), and standards vary considerably between regions. Heilpraktikers are specifically prohibited from practising obstetrics, dentistry, and venereology. For example a chiroprac has to get a heilpraktiker certificate to perform the practice.

[10] 'Kampo' is traditional Japanese medicine with the underlying idea of the human body and mind being inseparable and a balance of physical and mental health being essential for human health.

Traditional Chinese medicine practices in China experienced exclusion from the healthcare system, as well. The exclusion continued up to the country's policy of 1966 with the Cultural Revolution, which regulated traditional practices. In China 'old style' (meaning nationalist) intellectuals, artists, and doctors were tried to be remolded and united to become part of the revolutionary movement (Taylor, 2004). The aim of this revolution in China was to unite traditional Chinese medicine with the healthcare system while criticizing, educating about, and remolding the useful parts of old medicine (Taylor, 2004). Taylor defined this process as the 'politically right choice' of the revolution. Currently, China is the sole example of integrating TCM into a healthcare system with an independent education system and hospital choices (United Nations Educational, Scientific and Cultural Organization [UNESCO], 2013). Therefore, TCM practices as a whole bundle are accepted as legitimate in the Chinese context and there is no professional contestation among medical professionals over TCM. However, the same bundle was deemed illegitimate in the past (before 1966); thus, the state of legitimacy has been changed over the years depending on different criteria.

Western countries have seen professional attempts that may be regarded as part of legitimacy contestation among professionals (WHO, 2001). For example, homeopaths have a title protection in Germany. Such title protection exists for chiropractors in Canada. Osteopaths have independent professional associations in the US. On the other hand, in Italy, none of the TCM practices are accepted as medical, but medical doctors are free to choose any treatment while taking personal responsibility (WHO, 2001). In Italy homeopathy has had an association since 1947. France allowed chiropractic to be taught in the education system in 1953, although it was never taught in practice (WHO, 2001). Payment by insurance systems varies, as well.

According to the explanations made above, the legitimacy of TCM practices varies excessively among countries. In some countries, TCM practices are accepted as legitimate if a medical doctor applies the individual practice (for example, in France) (WHO, 2001). In some others, TCM practices are legitimate since they are paid for by general insurance (for example, in Canada). In some others they are accepted as legitimate if accepted as a medical profession (osteopathy in the US) or performed by a licensed practitioner (heilpraktikers in Germany). Therefore, it can be said that the variety of TCM legitimacy evaluation among countries changes according to the 'practice' or to the 'practitioner' and this variety seems to be affected by the unique medical history and political history of each country.

As explained above, TCM integration into healthcare systems reveals a legitimacy contestation related to the divergent nature of the practices. Some distinct characteristics of TCM practices lead to the presence of multiple legitimacy criteria. Scholars also accept that not all practices are in the same stage of legitimacy. Historical processes imply that some TCM practices experienced denigration from healthcare systems, which put them into an outcast position. Therefore, legitimation of TCM is not like a process of legitimation of an innovation or a new venture. Furthermore, professionals' contestations about TCM practices occasionally seem related to boundary work of non-medical TCM practitioners. However, there seems professional division regarding legitimacy of TCM practices as well.

Therefore, legitimation of TCM practices in a specific empirical context may provide some room for theorization of multidimensional legitimation process including legitimated practices as a bundle, multiple legitimacy criteria and professionals deploying different legitimacy criteria.

Therefore, Turkey as an empirical context may reveal distinct features in terms of its healthcare system, TCM integration, legitimacy contestations, and professional divisions. I present the Turkish Healthcare System (THCS) as an empirical context in the next chapter.

4. TURKISH HEALTHCARE SYSTEM AND TCM INTEGRATION

In this chapter, I explain the evolution of the THCS before and after the establishment of the Turkish Republic. Although these events may not always be directly related to integration of TCM into the THCS, they provide a contextual basis and information about some historical events affecting this integration. I then explain TCM integration into the THCS by specifying historical aspects of the evolution of TCM practices and regulative milestones of TCM integration. These two sections provide information about divergent nature of regulated TCM practices and the legitimacy criteria for evaluating them. The subsection on professional contestation regarding TCM provides information about legitimacy contestations among professionals regarding TCM integration. The section on diffusion of TCM in the THCS provides statistics about integration. The section on recent Turkish publications about TCM, outlines the construal of TCM in the field. Finally, I position my theoretical arguments within the opportunities of the empirical context in the last section of this chapter.

The Turkish Ministry of Health was established in 1920, which was among the first in the world. Establishment of the Ministry of Health can be accepted as the formation of the healthcare system as an organizational field. During the Ottoman Empire, there were some regulative actions towards standardization of health services. However, it was not before the Turkish Republican period that policy-based education and treatment standards of healing were put into action and diffused across the country.

To understand TCM integration into the THCS, it is necessary to summarize the Ottoman period as well as some TCM practices have roots in that period. That is why I will explain changes in the THCS in two historical periods in the following subsections before explaining TCM integration.

4.1. Healthcare System during the Ottoman Empire

Humoral pathology theory, religious prophetic medicine ('tıbbı nebevi'[11]), and folkloric medicine were diverse sources of medical knowledge and medical practice that co-existed in the Ottoman medical field (Baran, 2013; Gadelrab, 2013).

During this era, medical education was a part of other fields, such as philosophy (Bayat, 2010), and it was based on master-apprentice relationships (Çevikel, 2003). An institutional continuity can be observed between the old Anatolian Selçuk hospitals, with their charitable foundation systems, and Ottoman medical institutions, which were called 'darüşşifas'[12] (Baran, 2013; Çevikel, 2003). Besides this institutional continuity, medical knowledge was also inherited from other societies such as Greek-Roman, Egyptian, Arab, and Persian during the time of the Ottoman Empire.

Institutions of healing were called 'medrese', which provided education as well, and 'darüşşifa', in which apprentices were trained by master doctors (Baran, 2013). The title 'doctor' was not used in that period; instead, there were 'hekims', people with multidisciplinary knowledge including medicine, and a 'tabip' was a person healing people (Altıntaş & Doğan, 2004).

In the following periods, doctors (or rather 'hekims' at that time) were subdivided as state and private doctors. State doctors worked for the royal family in Ottoman palaces and some of them worked for the army, whereas private doctors offered healing services for the public (Altıntaş & Doğan, 2004). Although these doctors were private, they were also under state control after the establishment of the 're'îsü'l-etibbâ', which occurred in the 14th century, in the time of Sultan Murat II. The re'îsü'l-etibbâ was an institution responsible for the control and management of darüşşifas (Çevikel, 2003).

[11] 'Tıbbi nebevi' is the name of Islamic medicine, which is rooted in the hadith of the Prophet Muhammed and some verses of the Quran regarding healthcare.

[12] Hospital, medical school, and mosque complex.

During the 15th and 16th centuries there were no radical paradigm shifts in the medical field in terms of healing practices (Baran, 2013). In those years, applications of some TCM practices were very common; indeed, they were the sole treatment methods. One of the favorite Ottoman TCM practice was music therapy (Kabalak, 2017) (see Appendix D for a description of music therapy). The most important institutions in the Ottoman Empire using musical therapy were the Fatih Darüşşifa in İstanbul and the Edirne Darüşşifa in Edirne (Kabalak, 2017). Mental disorders were treated with a makam[13] of classical Turkish music, with a different makam being applied for different illnesses (Kabalak, 2017). Other TCM practices that were very common in those years were 'hacamat', or cupping therapy (see Appendix D for a description), and 'sülük', or leech therapy or hirudotherapy (see Appendix D for a description). According to Baran (2013), medical leeches were accepted as legitimate drugs and there was a large market for leeches in the Balkans and Ottoman Empire. Hacamat also constituted an important part of Ottoman medicine (Parlar, 2016), endowed with religious legitimacy as having been advised by the Prophet Muhammed (Baran, 2013; Parlar, 2016)[14]. In addition to these, in his famous medical book[15] that was gifted to Sultan Mehmed II, Şerafeddin Sabuncuoğlu mentioned two acupuncture points (Geçioğlu & Geçioğlu, 2014), indicating that, albeit accepted as Chinese conventionally, acupuncture was known in Anatolia in those years. According to some scholars, even foreign practitioners and medicine educators support TCM practices such as leeches and hacamat, as well (Baran, 2013).

Although according to Baran (2013) there were times of banning and punishment for some TCM practices, such as leech therapy, the regulations of healing largely focused on practitioners during the Ottoman Empire. In a decree dated 1592, it was requested from the

[13] Makam is a system of melody types used in Persian and Turkish classical music. There are thousands of musical examples of works written using hundreds of different makams in the literature of Turkish classical music. Makam names vary according to pitches used as well as general direction of the melodic flow (Kabalak, 2017)

[14] Religious legitimacy is defined as religiously appropriate (caiz) (Baran, 2013, p. 58), medical data that is legitimized by hadiths. The hadiths state that the prophet himself underwent the therapy (hacamat), implemented by an eshab , denoting a committed follower from the close circle of the prophet, but not necessarily somebody with medical expertise (Baran, 2013, p.50).

[15] Cerrahiyetül Haniyye

'hekimbaşı' (Head of the Doctors) to control doctors and eliminate those who were not qualified or who had not obtained appropriate education (Altıntaş & Doğan, 2004). Similarly, in 1729, Sultan Ahmet III ordered the hekimbaşı to examine the doctors, banning those who failed from working and giving a certificate to the successful ones (Altıntaş & Doğan, 2004). There were several other bans against bloodletting[16] by barbers and letting doctors freely choose their treatment methods (Baran, 2013).

During the 17th century, as the medicine discipline advanced in the west, the Ottoman Empire entered a period of revision in almost every area, including health. Thus, Ottoman medicine started to be modernized as well (Deniz, 2007; Salkı, 2008). The turning point for Ottoman medicine developing in a western style occurred during the era of Sultan Selim III, when in 1805 he allowed Greek minorities to open a medicine school (Çavdar & Karcı, 2014; Salkı, 2008).

It is Mahmud II who first established the Turkish Faculty of Medicine in 1827 (on 14 March 1827, a day still celebrated with a Medicine Fair in Turkey today), the Tıphane-i Amire (Bayat, 2010; Deniz, 2007; Dole, 2004). The Tıphane-i Amire was a military medicine school at the beginning. This was important for the history of Turkish medicine, since in the European/western medical system, inventions and treatment methods were taught to students independently of other disciplines (Dole, 2004). There were also European medical instructors in the Tıphane-i Amire, such as Ambrois Bernard from Vienna (Deniz, 2007; Dole, 2004). During the first decades of western-style medicine education, the language of training was French. In 1867 the first civilian medicine school was opened in Istanbul with the name of Mekteb-i Tıbbiye-i Mülkiye which gave an education similar to the Tıphane-i Amire (Bayat, 2010).

In 1871, legislation was passed that gave the responsibility for healing to doctors and pharmacists. With this legislation, those who did not possess a degree from the Tıphane-i Amire or a foreign medical school were prohibited from practicing medicine. This

[16] The first records concerning bloodletting by cutting veins, or venesection, are from the Hippocratic era in the 5th century BC. The idea involved the intentional removal of blood to eliminate the so-called peccant humors to restore the wellbeing of the person. The idea was supported by physicians like Hippocrates, Avicenna (Ibn Sina), and Galen, as well (Munshi et al., 2008).

prohibition against practitioners without medical degrees was so strict that upon the death of medical doctors it was requested that their medical diplomas be returned to the government during the 19th century, so that non-medical practitioners could not illicitly obtain them (İlikan, 2010). This legislation also included regular appointment of doctors to Anatolia (İlikan, 2013), which indicated diffusion of health services across the country via the state. The Ottoman period witnessed practitioner-focused regulations, which gave privileges to doctors with formal degrees.

In 1909, civil and military medicine schools were merged under the name of 'Faculty of Medicine', which was part of the Darulfünun (Aydın, 2002; Bayat, 2010; Deniz, 2007).

As explained above, the Ottoman Empire possessed information about some TCM practices such as cupping therapy, hirudotherapy, and acupuncture; these practices were well known by the society. Although not all of the TCM practices of the current world were known in that period, up to the 17th century, the approach to healing was based on holistic philosophy. Professional contestations regarding TCM did not occur. Healthcare regulations of the state provided authority and responsibility in healing to medical doctors, providing them with expert power. There did not seem to be any debate over treatment methods among those professionals during the Ottoman period.

4.2. Evolution of the THCS after Establishment of the Turkish Republic

Reforming a state by cutting its connections with the past was historically embraced and healthcare as an organizational field was a part of this revolutionary undertaking (Nasır, 1933). The role of the healthcare system in reforming the state has been accepted by some other authors, as well. For example, Dole (2004) explained that after the transition from empire to republic the Turkish state had a mission: to form a new citizen who was rational, who based his or her life on scientific facts instead of spiritualism, metaphysics, or religious things (Dole, 2004). This effort was supported by making health services easily accessible and by some publications and campaigns as well (Dole, 2004). Projects of nation-building, modernization, and development of the healthcare system were integrated in the first years of the Turkish Republic (İlikan, 2014). Thus, propagation of healthcare provision nested together with that of education of citizens in pursuit of modernity (İlikan, 2014). This period had an effect on the construal of the healthcare system in the following years, including medical education, patient-doctor relations, and professional tendencies of medical doctors.

After establishment of the republican regime, the Turkish healthcare system experienced different stages depending on the political tendencies and choices of the governments. In the first years of the republic, the main aim was to spread health services throughout the country. The main concern in those years was preventive medicine (Ekinci, 1980; Soyer, 2001). However, for social reasons following a period of war, most effort went toward fighting pandemic diseases such as pox or tuberculosis in those years. The Ministry of Health assigned doctors in some big cities such as Ankara, Trabzon, Kırklareli, and Gaziantep to report on the general health situation of their local region.[17] Most of those reports mentioned that people appealed to religious and superstitious healing systems since modern medicine was not widespread (Gökçe & Yaprak, 2012). Those healing systems were described as indicative of the backwardness of society, against which the government had to fight (Gökçe & Yaprak, 2012).

In 1928, the most influential law of the healthcare system passed: 'Tababet ve Şuabatı Sanatlarının Tarzi İcrasına Dair Kanun' (Law 1219) (Tababet ve şuabati san'atlarinin tarzi icrasına dair kanun, 1928). Article 1 of the law clearly stated that 'It is necessary to possess a medical school diploma to perform medicine or heal people within the boundaries of Turkish Republic'. This law continued the practitioner-based healing regulation of the Ottoman Empire, regulating not only pharmacists but also dentists, physicians, midwifes, and nurses, as well. This law can be accepted as the second step of field establishment in Turkey, apart from the Ministry of Health. Moreover, demarcation of the people authorized for healing by law enabled professionalism of the healthcare services. The professional boundaries of medical doctors were clarified. Medical doctors' responsibilities, such as obligatory registration in local professional associations (Art. 15), procedures for opening private clinics (Art. 12), and pricing of healing services (Art. 71), were addressed in the text of the law. Penalties were also specified for practitioners without medical degrees (PNMDs) (Art. 25) and for medical doctors in the case of abuse of authority (Arts. 26, 27). With time articles regulating some specialized healthcare professionals such as audiologists, clinical psychologists, pharmacist technicians, surgeons, and dialysis technicians were added to the law's text. Therefore, Law 1219 provided regulative legitimacy to the health practitioners by specifying their authorities and responsibilities.

[17] The report series was called Türkiye'nin Sıhhi ve İçtima-i Coğrafyası.

According to some authors, the 1933 University Reform (UR) was the starting point of the modernization of Turkish medical education (Bagatur, 2014; Ceylan, 2012; Erdem, 2012). During this reform process, Legal Act 2252 not only changed the name of the Darulfünun but also allowed for the firing of academicians who were found to be not satisfying the expectations of the new, young republic (Bagatur, 2014; Ceylan, 2012; Erdem, 2012). The reform involved revisions in the whole university system, including faculties of medicine, as well. Thus, after the 1933 UR, western-style medical education in Turkey accelerated. Modern medicine has been dominant in the THCS since then (Ceylan, 2012; Erdem, 2012). Medical education now included concerns about modernization and moving away from the past (İlikan, 2014); therefore, medical education in Turkey has been dominated by modern medical inventions and progress since then.

According to the medical deontology act of 1960 (Law 1960), doctors are free to select whichever treatment method they prefer to apply to a patient in accordance with scientific rules (Tıbbi deontoloji nizamnamesi, 1960). Although medical doctors were provided such freedom by law, as long as they obeyed ethical rules, in practice there is constraint in treatment method selection. This constraint originates from medical education. Knowledge regarding which treatment to choose and any other possible knowledge a doctor may attain depends on the training and education he or she receives from either the faculty or additional training programs.

After World War II, relations with the WHO and other international organizations such as UNICEF were established. According to some authors, those years were the starting point of a shift in health policies to treatment-based medicine from preventive medicine (Soyer, 2001). Some authors view this policy shift as an initiation of the marketization of healthcare provision in Turkey. Marketization of the healthcare defined with two dimensions: (1) a shift towards commercial concerns among healthcare providers, which reflect market forces such as profitable sale of goods and services, (2) substantial increase in the number of for-profit forms of offering healthcare services (Scott et al., 2000, p. 61).

After the 1980s, with the influence of globalization and freedom of capital exchange (İzgi & Çoban, 2014), the neoliberal policies of the governments started to influence the healthcare system (Kavas & İlhan, 2010). In the following years, treatment-based healthcare services increased, which emphasized laboratory survey methods in diagnosis (İzgi & Çoban, 2014).

In 2003, the Ministry of Health announced the 'Health Transformation Program', which aimed to organize the provision of healthcare services in an efficient, productive, and fair manner including a repayment system. The most influential part of this program was the merging of government-paid insurance systems into a single system. The program included encouraging the private provision of healthcare services. According to some, privatization of healthcare services shows the aim of the state to focus on health insurance issues (Çavmak & Çavmak, 2017). On the other hand, for others, this program converted the provision of healthcare into a 'saleable object' instead of an international citizen 'right' (İzgi & Arda, 2012). For some local professional associations, the health transformation program included an ideological and political imposition of the 'conservatization' of the healthcare system, which was associated with the regulation of TCM practices as well (Ankara Tabip Odası [ATO], 2017).

The evolution of the THCS after the establishment of the Turkish Republic reveals information about legitimacy criteria for healing people implicitly. The sole authority for healing people is given to medical doctors. Besides, both state regulations and reforms regarding the healthcare system have enhanced the rules of modern medicine and thus conditions for the choice of treatment method by them. There is no contestation among professionals regarding the treatment method they choose for patients.

I have briefly explained the evolution of the THCS before and after the Turkish Republican period. Although these two subsections are not directly related to TCM integration, they provide contextual information about the THCS, which experienced a modernization period for years. In what follows, I will summarize the historical and legal processes of TCM integration in the THCS, relevant professional contestations, and diffusion of TCM in the field, as well.

4.3. TCM Integration into the THCS

4.3.1. Historical Influences on TCM Practices

In Turkey, the first legally approved TCM practice was acupuncture in 1991. However, there are four important points of the field's evolution, which have reflections on TCM practices in terms of legal and professional progress in Turkey.

(1) Political and ideological impacts of using the healthcare system as a tool of modernization.

(2) Law 1219, which demarcated the professional boundary of the field by authorizing officially, trained medical doctors in healing people.

(3) Law 1960, which gave medical doctors freedom of choice for the appropriate treatment methods they can apply.

(4) The medical education system.

Among these four points, the 2nd and 3rd are related to professionals, mapping their jurisdictional authority by law and providing responsibility over their authority as well. These points can be accepted as having more explicit results for the THCS, providing regulative, professional and public legitimacy (which can be assumed as approval by the general society) to medical doctors. Indeed, there is no dispute over the authority of medical doctors in Turkey and whatever they practice is accepted as legitimate in terms of healing (though there may be some exceptions, such as malpractice[18] situations) (Çetin, 2006; Geçioğlu & Geçioğlu, 2014). There is no social movement among the public requesting regulation of TCM practices or supporting evidenced-based or scientific medicine, such as in the cases of the UK or Austria (Broom & Tovey, 2007; Brosnan, 2015). Therefore, it can be said that professional legitimacy of medical doctors is very strong in Turkey, supported by regulative legitimacy.

On the other hand, the 1st and 4th points have some implicit reflections in the field, albeit difficult to measure. The first point provides a general understanding that supports medicine as a guardian of modernization and rationality. Indeed, this understanding suppresses anything traditional, putting it in an outcast position. Some TCM practices experienced such exclusion in Turkey, albeit not banned by law. Besides, Turkish medical schools, as mentioned above, have provided curriculums in accordance with modern medicine for years. Under the effect of the 1st and 4th points, the healthcare field is dominated by modern medicine and scientific and rational paradigms. Thus, this constitutes a format for medical doctors' choice of treatment method. On the other hand, the 1st point may have reflections on the professionals of the field leading some schism among them which have not directly related with their field or profession.

[18] 'Malpractice' refers to a situation in which the patient is harmed as a result of a doctor's unstandardized treatment, a doctor's lack of required competence, or a doctor not giving any treatment (Geçioğlu & Geçioğlu, 2014).

The knowledge of TCM was left to those without medical degrees, who are indeed not authorized to heal people. Therefore, there emerged an unofficial field of TCM, which is not under state control and not under the professional control of medical doctors (Mollahaliloğlu et al., 2015; Şimşek et al., 2017). This led another reflection on TCM practices, putting them into an inferior position and disregarded by medical doctors.

Despite the disadvantageous position of TCM practices, they made inroads into the THCS, which provided 15 of them with state regulative legitimacy in 2014. I will now summarize the steps of TCM integration by years before and after the legislation passed in 2014.

4.3.2. Milestones of TCM Integration in the THCS

Some TCM practices such as cupping therapy (i.e. hacamat), some manual therapies, and leeches have been used in society, outside of the THCS, as mentioned before. However, in 1978 for the first time an individual TCM practice captured public attention. The Minister of Health, Mete Tan, visited China and published an article series regarding his observations on acupuncture and traditional Chinese medicine (Acar, 2016). Indeed, some medical doctors were practicing acupuncture in their private clinics or in public hospitals in those years (Acar, 2015; Kuzulugil, 2015). Acupuncture was seen as belonging to Chinese medicine and no one treated it as 'traditional' medicine practice in those years.

In the 1980s there were some regulations related to herbal drugs, which focused on the control of the related market. Herbal products have been sold in pharmacies or in herbalist shops in Turkey. During the 1980s, pharmacies were authorized to control herbalist shops and a guideline for the control procedure was distributed to them. However, these regulations were far from systematizing phytotherapy (See Appendix D for the explanation of Phytotherapy) as an individual TCM practice.

As mentioned above, the first TCM practice to be regulated was acupuncture in 1991 via the 'Acupuncture Treatment Bylaw'. This bylaw accepted acupuncture as a legitimate treatment method and called certified practitioner doctors 'acupuncturists', which formed a new professional scope among medical doctors. An acupuncture supreme commission was also created to study the progress of acupuncture, which with time became an influential actor in TCM integration into the THCS. The acupuncture bylaw was revised several times, in 2002, 2005, 2008, and 2012 (Katı, 2016). Finally, it was phased out with the passage of TCM legislation in 2014.

According to the directives of the European Union, traditional herbal medical products legislation was passed in 2010, which underwent several revisions in the following years, as well. However, it did not provide any standardization to phytotherapy. In 2011, another bylaw was passed, allowing pharmacies to sell some homeopathic drugs, and the İstanbul University Traditional Drugs Research and Application Center was established, as well. Regarding herbal medicines, research and application centers were established in the following years at several universities.[19]

In 2012, the Ministry of Health started to study legislation to legalize some TCM practices and organized two workshops inviting representatives of some TCM associations.

Before the TCM legislation was released, TCM research and application centers were established at several universities. These centers were not authorized by the Ministry of Health but established by the Higher Education Institution (YÖK). Table 3 summarizes these centers between the years of 2011 and 2018.

Table 3 TCM Research and Application Centers (according to YÖK) established before and after legislation

Year	TCM Research and Application Center
2018	Dokuz Eylül University Hitit University Necmettin Erbakan University
2017	Düzce University Bezmiâlem University Karabük University Trakya University
2016	Sağlık Bilimleri University
2015	Hacettepe University Giresun University Sakarya University

[19] 2014- Gümüşhane University Research and Application Center for Medical Plants and Traditional Drugs and İnönü University Research and Application Center for Traditional and Folk Drugs; 2015- Necmettin Erbakan University Research and Application Center for Medical and Cosmetic Plants; 2016- Dumlupınar University Research and Application Center for Medical and Aromatic Plants.

2014	Legislation
2014	Cumhuriyet University Adnan Menderes University Gazi University
2013	Üsküdar University İstanbul Medipol University Yıldırım Beyazıt University Dumlupınar University
2011	Ataturk University

In 2011, the Department of Traditional, Complementary, and Alternative Medicine was established within the structure of the Ministry of Health, though the term 'alternative' was removed from the name of the department because of reaction against it (see Appendix A for the dispute over terms). In 2012, in cooperation with associations, practitioners, and the demanding parties, 44 TCM practices were taken into consideration for integration (Döker, 2014). In the same year, TCM practices, regulations, and research necessities were included in the 2013-2017 Strategic Plan of the Ministry of Health. Before the legislation was passed, a proposal was announced on the Ministry of Health's website in January 2014, calling for every related party to send its comments on it.

In March 2014, Hacettepe University added phytotherapy (they defined it as the science of herbs) under the name of 'Fitoterapi' to its Pharmacy Faculty curriculum as an elective course.

In October 2014, complementary and traditional medicine legislation, as a bylaw, was announced, officially allowing 15 TCM practices to be conducted in hospitals by certified medical doctors and some assisting medical staff (see Appendix D for descriptions of regulated TCM practices). In determining the practices to be regulated, the Ministry of Health developed a scoring system and based its evaluation on it. The evaluation of the practices was a result of research about frequency of usage in Turkey, observations from visits to other countries' TCM centers, literature review, and CAMbrella and WHO reports (Döker, 2014). Finally, 15 practices to be regulated were determined by taking into consideration the following concerns (Döker, 2014);

(1) Evidence-based foundation (number of publications in Cochrane and PubMed databases)[20]

(2) Prevalence in Turkey (whether or not professional associations exist; organization of workshops or congresses)

(3) Prevalence in other countries

(4) Regulatory status in other countries

(5) Educational status in other countries

(6) The scope of application s (indications and contraindications)

(7) Characteristics of the practitioners in Turkey

Here the multiplicity of legitimacy criteria in evaluating regulated TCM practices emerges. The scoring system also reveals that not every TCM practice is in the same stage in terms of multiple criteria (Mollahaliloğlu et al., 2015).

4.3.3. Professional Contestation Regarding TCM in THCS

Although there seem to be clear legitimacy criteria used by regulators in determining which practices to legalize, TCM legislation brought about contestation among professionals. Therefore, TCM integration got regulative legitimacy whereas it lacks professional legitimacy. Furthermore, legislation mobilized actors towards some actions like resisting the integration (as some professional associations did), expressing ignorance (as a majority of the medical doctors did), taking certificates, seeking approval for certificates received from institutions other than the Ministry of Health, or organizing certificate training programs. Below are some examples of contestations among professionals in the field.

Although the title of the legislation includes the terms ‘traditional’ and ‘complementary’, the text does not include any definition of them and the legislation does not define whether the regulated practices are ‘traditional’ or ‘complementary’. This situation brought many divisions among medical professionals.

[20] Global independent database networks for healthcare research.

The embeddedness of the regulated TCM practices in Turkish culture also differs. Some practices such as mesotherapy (see Appendix D for a description) originated in foreign contexts (France, in the case of mesotherapy) and were imported to the Turkish healthcare system. Similarly, some of them, such as prolotherapy, arose in U.S. within the scope of the field of modern medicine as a complementary practice and have not experienced any exclusion process, neither in the home country nor in Turkey. Some practices such as homeopathy were excluded in one context (USA) but not in others. Finally, some practices belonging to Turkish culture, such as music therapy, were ignored in treatments and not included as an official treatment practice in medical education, and thus knowledge of it is about to disappear.

By contrast, some traditional practices such as cupping therapy or hirudotherapy embedded in Turkish culture are not taught in medical education and are thus seen as inferior treatment methods. Therefore, the meaning attached to each TCM practice differs widely in spite of them all being included in the same bundle for regulation.

Ultimately, it is difficult to say that all of the regulated practices possess the same meaning and belong to the same cognitive category in the minds of medical doctors. This varied nature of TCM practices may be the first reason for the professional divide regarding TCM integration. Table 4 summarizes the regulated practices (see Appendix D for descriptions of the regulated practices).

Table 4 Regulated TCM Practices in Turkey

		Historical Embeddedness to Turkish Context	
		High	**Low**
Relative Scientific Base	**Strong**	Phytotherapy	Acupuncture Apitherapy Maggot Therapy Prolotherapy Reflexology Chiropractic Mesotherapy Osteopathy Ozone Therapy
	Weak	Cupping Therapy Hirudotherapy Music Therapy	Homeopathy Hypnosis

The contestation among professionals started during the legislation's proposal stage and became deeper after its official publication. Relevant parties seem divided as proponents and opponents of the regulation. On one side, proponents think that it is necessary to governmentally standardize and control TCM to improve the quality, while others who do not believe in these practices' efficacy claim that it is dangerous to legitimize them in the hands of the state (Unstructured e-mail interview with Ministry of Health officer, December 2014). Some other parties are glad about the regulation but complain about authorization of medical doctors solely (Unstructured e-mail interview with Ministry of Health officer, December 2014). Therefore, the legislation has created significant professional division in terms of legitimacy of the TCM practices.

The Turkish Medical Association (TMA) and other specialty associations emerged as the most salient opponents to the integration of TCM into the THCS. As a first reaction, the

TMA opened a case for the cancellation of the TCM legislation. In 2016, the group organized a symposium for discussing the indications, potential abuses, and potential risks of some TCM practices with the participation of specialty associations. They also opposed the legislation in some publications (Ankara Tabip Odası, 2017; Türk Tabipleri Birliği Halk Sağlığı Kolu, 2017) and with the release of special issues and some opposing articles in the journals Toplum ve Hekim and Hekim Postası.

On the other hand, proponents released publications outlining the necessity of regulation and supporting the legitimacy of some TCM practices (Mollahaliloğlu et al., 2015; Şimşek et al., 2017). Despite these contestations, TCM integration diffused into the field, which will be explained in the next section by numbers.

4.3.4. Diffusion of TCM in THCS Despite Debates

Educational standards were released for 14 of the regulated fields (excluding chiropractic) and some TCM application centers were authorized for providing certificate training. Table 5 summarizes the education centers for TCM as of June 2018 according to the official web site of Ministry of Health.

Table 5 TCM Education Centers in Turkey as of June 2018

Acupuncture	**Phytotherapy**	**Osteopathy**	**Hirudotherapy**	**Hypnosis**
Gazi U. Yıldırım Beyazit U. Atatürk U Cumhuriyet U. Medipol U. Bağcılar EAH Kayseri EAH Adnan Menderes İnönü University Ankara Keçiören Umraniye EAH Yeditepe U. Konya NE U.	Yıldırım Beyazit U. Bezmi Alem U Bağcılar EAH Medipol U. Gazi U. EGE U. Adnan Menderes Umraniye EAH Yeditepe U. Konya NE U.	Yıldırım Beyazit U. Bağcılar EAH Konya NE U.	Bağcılar EAH Kayseri EAH Gazi U. Yıldırım Beyazit U. İnönü University Sakarya U. Umraniye EAH	Yıldırım Beyazit U. Bağcılar EAH Kayseri EAH Atatürk U Adnan Menderes Antalya EAH Umraniye EAH Gazi U. Medipol U.
Apitherapy	**Homeopathy**	**Chiropractic**	**Cupping Therapy**	**Maggot Therapy**
Kayseri EAH	Yıldırım Beyazit U.	None	Bağcılar EAH	Adnan Menderes
Yıldırım Beyazit U.	Bağcılar EAH		Kayseri EAH	Bağcılar EAH
Antalya EAH	Medipol U.		Medipol U.	Yıldırım Beyazit U.
Bağcılar EAH			Gazi U.	
Medipol U.			Yıldırım Beyazit U.	
			Adnan Menderes U.	
			İnönü University	
			Sakarya U.	
			Ankara Keçiören EAH	
			Antalya EAH	
			Umraniye EAH	
			Bağcılar EAH	
			Konya NE U.	
Mesotherapy	**Prolotherapy**	**Ozone Therapy**	**Reflexology**	**Music Therapy**
Bağcılar EAH	Yıldırım Beyazit U.	Kayseri EAH	Bağcılar EAH	Bağcılar EAH
Yıldırım Beyazit U.	Gülhane EAH	Yıldırım Beyazit U.	Yıldırım Beyazit U.	Yıldırım Beyazit U.
Gazi U.	Bağcılar EAH	Gazi U.		Medipol U.
Medipol U.	Konya NE U.	Umraniye EAH		
		Bağcılar EAH		
		Konya NE U.		
		Medipol U.		

TCM application centers and units also increased across the country, as Table 6 and Table 7 summarize.

As can be seen in Tables 5, 6, and 7, education centers, application centers, and units are scattered throughout Turkey. Acupuncture, cupping therapy, and hirudotherapy appear as most prevalently taught and practiced TCM practices.

Table 6 TCM Application Centers (Authorized by the Ministry of Health) as of June 2018

Name of the TCM Application Center	TCM practice applied
Konya Selçuk U.	Acupuncture/Hypnosis
İstanbul Yeditepe U.	Acupuncture
Harran U.	Acupuncture
Adnan Menderes Üniversitesi U.	Hypnosis
Konya Necmettin Erbakan U.	Acupuncture/Prolotherapy
Sakarya U.	Acupuncture /Cupping Therapy
Cumhuriyet U.	Acupuncture
Ege U.	Acupuncture-Phytotherapy
Hacettepe U.	Acupuncture
İstanbul Medipol U.	Acupuncture/ Cupping / Ozone/ Homeopathy / Apitherapy
Bezmialem Vakıf U.	Phytotherapy/Acupuncture
Ankara Yıldırım Beyazıt U.	Acupuncture-Cupping-Ozone-Hirudotherapy-Hypnosis
Gazi U.	Acupuncture
Fırat U.	Acupuncture/Ozone Therapy
Başkent U.	Acupuncture
Balıkesir U.	Acupuncture
Atatürk U.	Hypnosis -Acupuncture
Istanbul Biruni U.	Acupuncture /Hirudotherapy/Cupping/Mesotherapy/Prolotherapy/Ozone
İnönü U.	Cupping/Hirudotherapy/Acupuncture
19 more public hospitals belong to Public Hospitals Union in Ankara, İzmir, İstanbul, Antalya, Kayseri, Konya, Aksaray, Niğde, Sakarya, Karabük and Elazığ cities	Acupuncture in 13 centers Cupping Therapy in 12 centers Mesotherapy in 1 center Ozone Therapy in 7 centers Hirudotherapy in 4 centers Phytotherapy in 1 center Prolotherapy in 2 centers

Table 7 TCM Units (Authorized by Ministry of Health) as of June 2018

Name of Public Hospital in Which TCM Unit Exists	TCM practice Applied
Antalya Atatürk Public Hospital	Acupuncture
Kayseri Develi Hatice Muammer Kocatürk Public Hospital	Cupping - Hirudotherapy
Bartın Public Hospital	Cupping therapy
Bolu İzzet Baysal Physical Therapy Public Hospital	Acupuncture
Aksaray Public Hospital	Acupuncture
İstanbul Kağıthane Public Hospital	Acupuncture
Ankara Halil Şıvgın Çubuk Public Hospital	Acupuncture
Bursa İnegöl Public Hospital	Acupuncture-Cupping Therapy
Mersin Toros Public Hospital	Acupuncture
Kocaeli Darıca Farabi Public Hospital	Acupuncture, Hypnosis Phytotherapy, Cupping therapy
Antalya Finike Public Hospital	Cupping therapy-Hirudotherapy Ozone Therapy - Mesotherapy
Ankara Gazi Mustafa Kemal Public Hospital	Acupuncture, Cupping therapy Mesotherapy- Prolotherapy
Muğla Dalaman Public Hospital	Acupuncture
Fethiye Public Hospital	Acupuncture
Fatsa Public Hospital	Cupping Therapy
Polatlı Duatepe Public Hospital	Phytotherapy, Cupping therapy
Şile Public Hospital	Ozone Therapy
Eskişehir Public Hospital	Acupuncture
Sapanca Public Hospital	Cupping Therapy

Here emerges another issue in TCM legislation: the difference between a TCM application center and a TCM application unit. TCM application centers are different from research centers authorized by YÖK. TCM application centers authorized by the Ministry of Health have the authority to both provide education and administer TCM treatments to patients. On the other hand, units only have the authority to treat patients. There are also different indication lists for these two entities, which creates ambiguity of responsibility among professionals.

TCM integration into the THCS by steps, including professional divisions and diffusion, has been outlined up to this point. Next, I will summarize some TCM-related publications in Turkey, which reflect the attitude of the public and professionals as well.

4.4. Recent Turkish Publications about TCM

Turkish scholars have conducted some local studies, which may give ideas about the TCM field's current situation in the country. These will be summarized in this section.

No nationwide study has been held in Turkey regarding TCM practices except only one (Şimşek et al., 2017). The sole publication included results of the preliminary survey undertaken by the Ministry of Health during its legislation work. This study is important since it includes data from all regions of the country (Şimşek et al., 2017).

However, the article did not use data on professionals. According to the results, the five most commonly used TCM practices in Turkey are herbal mixtures (59.1%), hirudotherapy (17.6%), praying (15.2%), cupping therapy (13.7%), and acupuncture (11.2%). According to the authors, the results reflect the cultural context of Turkey since in similar studies in foreign countries, TCM practices like praying, cupping, or hirudotherapy are not so common. In addition, application by practitioners without medical degrees was noted. Finally, the authors emphasized the divide between traditional and complementary medicine, which was proposed to be evaluated separately.

In another study of patients in Erzurum (Tan, Uzun, & Akçay, 2004), the authors mentioned the need perceived by medical professionals for education about TCM in order to be able to inform patients when they ask any questions. They also proposed that the government should provide more support and encourage research in this field because public interest is high.

There are some studies conducted with professionals, as well. For example, one involving nurses and physicians in the Gülhane Military Medical Faculty Training Hospital in Ankara (Özkaptan & Kapucu, 2014) found that subjects had limited knowledge but expressed positive attitudes regarding their wish to apply TCM practices. According to their results physicians working less than 10 years (48.8%) and 37.7% of physicians working more than 10 years were very positive and wanted TCM available for the therapy and care of patients (Özkaptan & Kapucu, 2014, p. 916). The same authors also mentioned that due to the lack of governmental regulations, the implementation of TCM practices is scarce and left to laypeople who charge high prices and practice in bad conditions (Özkaptan & Kapucu, 2014). In a study held with general practitioners in Bursa, 96.5% of the subjects reported that they had no education related to this field, 74% of them stated that they wanted to learn more, and 62% of them believed in the necessity of TCM education (Özçakır et al., 2007).

In another study held in İzmir with medical students, including nursing students, 58% of the subjects agreed with the integration of these practices into clinical practice and 61% of them agreed with curriculum inclusion (Yildirim et al., 2010). Uzun and Tan (2004) found that

nursing students had positive attitudes but limited knowledge about TCM, 64% of them wanted TCM to be integrated into the curriculum, and 62% of them wanted it to be integrated into clinical practice, as well. Subjects also mentioned patients' desires for these treatments and said that they face questions from them (Uzun & Tan, 2004).

These studies all show that many medical professionals (including nurses and doctors) have limited knowledge regarding TCM, most of them want to learn about these practices, and most of them want TCM to be integrated into the education system, as well. Both studies held with patients and with medical professionals demonstrated interest among people towards TCM. Finally, almost all studies mentioned the necessity of regulation by the government. In addition, these studies suggested an inferior position of some TCM practices, although there is no sign of any social movement towards regulation or deregulation.

On the other hand, the extant literature focuses on the frequency of TCM practices across regions and factors determining patient choice. There are expressions that reflect patient evaluations, such as 'perceived effectiveness' (Araz & Bulbul, 2011) or 'feeling better both physically and emotionally' (Algier, Hanoglu, Özden, & Kara, 2005). However, studies are silent about professionals' perceptions and evaluations of TCM practices, except for some exceptional studies providing suggestions for professionals to rethink TCM practices (Gözüm, Tezel & Koc, 2003).

4.5. Justification of the Empirical Context

The historical context of the THCS brought some conditions to the field, such as dominance of modern medicine in medical education that have made TCM integration difficult. There are also differences among individual practices; for example, some of them are well known in society (e.g., cupping therapy) and some of them are not (Büken et al., 1996).

Legally, TCM integration into the THCS was initiated by a bylaw. The criteria used by regulators during the regulation process (Döker, 2014) brought about multiple legitimacy criteria that are accepted to define any TCM practice as an applicable treatment method. On the other hand, many professionals questioned the legitimacy of some or all of those regulated TCM practices, which created a contested legitimacy situation. Although there seems to be a necessity for regulation because of the public demand, WHO initiatives, and professionals' interest, there is conflict over the safety and efficacy of these practices among professionals.

The situation of TCM integration into the THCS may provide an empirical realm for the theorization of legitimation as a multidimensional process which includes practice, legitimacy criteria and professionals as main dimensions.

First, the divergence among different TCM practices, in terms of their type (whether TM or CM) or in terms of the dimensions provided in Table 4, constitutes their heterogeneous nature. Therefore, the practice to be legitimated, namely TCM practices, is not a single practice as studied by the extant literature of legitimation. Instead, TCM practices constitute a bundle of practices each of which has different scientific, historical and philosophical background, indication and contraindication scope and public avalibility. However, state regulated them in the same bundle, giving rise to a potential spillover among practices, which I want to observe as determinant interaction of the legitimation process. Besides, some of the legitimated TCM practices are not invented currently and they do not constitute a new venture as studied by the extant literature of legitimation. Instead, some TCM practices are outcast in nature, historically denigrated from the THCS albeit not banned officially. Thus, the form of the practices may constitute a distinct dimension of the legitimation process.

Second, there are multiple criteria of legitimacy proposed by regulators, professionals, and their associations as well. The existence of multiple criteria constitutes an opportunity to theorize how legitimators, namely professionals in this study, combine those criteria. Besides, professionals in THCS questions rationality of the state thus regulative legitimacy (such as the reaction of TMA). Moreover, some professionals depart from established normative rules (that is scientific paradigm of the modern medicine) thus depart from normative legitimacy. Therefore, there may be possibility of capturing emergent legitimacy criteria deployed by the professionals in THCS for the legitimation of TCM practices.

Third, there is professional contestation in terms of TCM integration into the THCS. The regulation provided the sole authority of TCM practice to medical professionals. Therefore, the contestation among professionals may not be about the expert power. Instead, they is a schism in terms of their approach to TCM practices, i.e. their services in terms of treatment method administered to patients. Besides, historical and contextual factors may lead professionals to be in different positions which are not directly related with the healthcare system. Therefore, the divisions and contestations among professionals in the THCS may provide an opportunity to theorize a distinct form of legitimation, in which professionals are under the interaction with legitimacy criteria and practices. The initial professional division

regarding TCM integration into the THCS seems to comprise two groups of proponents and opponents, which is in accordance with the existing literature. However, a legitimacy contestation of this kind, which involves multiple legitimacy criteria with a bundle of legitimated practices (i.e. TCM practices), may lead to the emergence of different professional types.

THCS regarding TCM integration seems providing suitable empirical context for the theoretical aim I want to refer. That is to conceptualize legitimation of TCM practices into THCS as multidimensional legitimation process, which involves legitimacy criteria, legitimated entities (TCM practices) and legitimators (professionals) in the same frame. Therefore, I will explain my research design, participants, data collection, data analysis, and results in the methodology and findings chapters next.

5. METHODOLOGY

5.1. Research Design

This research is qualitative in nature, based on a three-year observation of legitimation of TCM practices in the THCS. Although it is qualitative research, the study is not designed as a grounded theory in which the theory is obtained from the data (Glaser & Strauss, 1967). Instead, some predefined categories of legitimacy, professionals, and healthcare literatures (Bitektine & Haack, 2015; Corley & Gioia, 2011; Currie & Spyridonidis, 2016; Gioia, Corley & Hamilton, 2013; Suddaby et al., 2017) have conditioned the research from the beginning. On the other hand, the research is not structured as strictly as a reductionist content analysis, either.

The aim is not to reach generalizability and identify how many participants shared which characteristics (Grant, 1988). Instead, the goal is to narrate how they construe the process in their own words. Then, I revised the design as the research progressed, following iterations between theory and data (Glaser & Strauss, 1967), sometimes even modifying the initial research aims (Gioia et al., 2013).

It is not possible to identify clear consequences of the integration process of TCM into the THCS since the TCM regulation is very recent. Therefore, this study was designed as process research of an evolving phenomenon (Langley, Smallman, Tsoukas, & Van De Ven, 2013), which required stage-based data collection and analysis.

The analysis was done according to the stepwise method of Strauss and Corbin (1998), which includes various coding processes. In this study coding is used as the analysis method inspired by the expression of Miles, Huberman and Saldaña's (2014) generic expression that 'coding is analysis'. The codes[21] condensed towards categorized data chunks which were particularly related with the aims of the study that is to theorize dimensions of legitimation process so as to conceptualize it as a multidimensional process.

[21] A code in qualitative inquiry is most often a word or short phrase that symbolically assigns a summative, salient, essence-capturing, and/or evocative attribute for a portion of language-based or visual data (Saldaña, 2009)

The study began in April 2015 with some initial explorative field observations and concluded in March 2018 when the data analysis of all related data was concluded. The first 25 interviews constitute the first stage of the study and were collected between November 2015 and March 2016. The second stage of the study was held between October 2017 and December 2017, which included additional 27 interviews, 3 field observations, and collection and analysis of other data sources. There is an interval between these two stages since several iterations between data and literature occurred after the first stage. Those iterations directed the theoretical and empirical decisions of the second stage of the research.

Semi-structured interviews constituted the main data of the study, whereas archival documents, press releases, online publications, and field observations were used for triangulating the findings. The stage-based nature of the study provided triangulation by time and person as well (Berg, 2001), which means different people in different times and the same people in different times participated in the research.

Ethical permission for the study was received from the Ankara Yıldırım Beyazıt University Ethics Committee before the first group of interviews started. Each participant was informed about the content and purpose of the study. The standard informed consent form of Ankara Yıldırım Beyazıt University was used and participants' ink-signed signatures were obtained. Three of the participants did not allow voice recording, so detailed notes were taken during their interviews. The rest of the interviews were audiotaped and transcribed verbatim. Each participant was free to conclude the interview whenever he or she wished.

Archival documents, press releases, and online publications are publicly available. Field observations were conducted with the permission of the related authorities of the application centers or units. Details about participants, interviews, and other data sources will be explained in the following sections.

5.2. Sampling

5.2.1. Sampling in the First Data Collection Stage

In the first data collection stage of the study, participants were sampled purposively as a convention of qualitative study (Miles, Huberman, & Saldaña, 2014). The aim of the first stage was to acquire as many ideas as possible to capture the context in detail. In this first stage of the research, my initial research aims were more general than it was at the end. Thus, not only professionals but also patients, practitioners without medical degrees (PNMDs),

and some other related participants such as officers of the Ministry of Health were included in the sample at this stage.

I tried to ensure variance in responses to the integration of TCM into the THCS. Thus, sampling decisions were guided by informed guesses based on backgrounds checks that gave clues as to the stance of the potential participants, as well as the extent to which they would be knowledgeable about characteristics of TCM practices or the regulative steps of the integration process.

First, I found the list of participating advisors of the Ministry of Health's pre-legislation workshops. Then I examined their curriculum vitae and considered their accumulated knowledge of TCM from their experiences. I checked authors of the publications that were opposed to the TCM regulation, as well.

Therefore, the initial sample consisted of 17 medical doctors, 2 users of TCM, 1 PNMD, 2 pharmacists, 1 dentist, 1 biologist, and 1 physiotherapist. I chose the TCM practitioner participants from among those who took part in the legislation process. Representatives of the TCM-related associations, the Turkish Medical Association (TMA), and local medical associations including the Professional Association of Pharmacists and Bioethics were included, assumed to be in opposition to the regulation. Representatives from the Ministry of Health were included to reflect on regulative aspects. Users and the PNMD were interviewed to see how they construed the regulation and the TCM field.

All of the practitioners in the first stage received their practice certificates before the 2014 regulation and all of them practiced acupuncture. Some also practiced other regulated practices.

5.2.2. Sampling in the Second Data Collection Stage

As a result of the first stage of data collection, data were analyzed with some coding procedures appropriate for this first stage of analysis[22.] Then the initial results were

[22] See the 5.5.2. Initial coding of the first group of interviews section to see coding methods used for the analysis of the first group of interviews.

compared with the existing literature. This initial analysis shaped the sampling decisions of the second stage and led me to sample medical professionals specifically.

Medical doctors are at the apex of the healthcare professional hierarchy with their power derived from the social legitimacy of their mission and the exclusive ability to apply their expert knowledge (Currie, Lockett, Finn, Martin, & Waring, 2012, p. 940). In the Turkish context, integration of TCM into the THCS is questioned, criticized, or supported by professionals of the field and thus legitimacy contestation among them became apparent, as explained before (see Chapter 4 for the initial debates between professionals of the field). The first stage of data collection also revealed to me that professionals might provide more systematic qualitative data.

Therefore, in the second stage of the data collection, all participants were medical professionals who were sampled theoretically, i.e. sampled on the bases of emerging concepts of the first stage (Glaser & Strauss, 1967; Strauss & Corbin, 1998). The sampling decision was based on the emerging concepts of the first stage of the interviews and also was based on the predefined codes from literatures, so I knew where to go from that point to increase similarities and differences in professionals' construal of the legitimacy of TCM practices, legitimacy criteria they used, and the contestations among themselves about TCM practices.

The aim was to discover variations among emerging and predefined concepts and to identify categories in terms of dimensions and relations (Strauss & Corbin, 1998). Therefore, I chose to not only vary the participants in terms of their backgrounds but also to check their current attitude towards TCM regulation, their publications (in favor or in opposition of TCM), and their status as being a scientific committee member of the Ministry of Health's TCM department or being educator of TCM. I also tried to reach TCM practitioner participants who practiced different TCM practices.

The second stage of the interviews included 24 medical doctors, 1 dentist, 1 pharmacist, and 1 PNMD. There was a 19-month interval between the first stage of interviews and the second stage. Therefore, in the second stage of data collection, I re-visited four of the participants from the first stage.

There was an emerging actor type in this stage, who stated during their interviews that they had no idea about TCM practices or had an adverse attitude towards TCM before the

legislation, but then took a certificate and started to practice after the legislation. Nine of the medical doctors in this stage fell into this group according to their interview excerpts, in which they revealed changes in their approach to TCM practices.

I continued to expand the sample until theoretical saturation was reached. I decided the data were theoretically saturated since no new emerging category was added (Strauss & Corbin, 1998). At the end of each interview, I also asked the participants for their advice on snowballing. This allowed me to see saturation, since the names being advised were those of individuals I had interviewed already.

Transcriptions of users, the PNMDs, and the sole biologist[23] of the sample (albeit transcribed verbatim) were excluded from the analysis. Practitioners of all of the regulated practices were included in the final sample, except maggot therapy.[24] The final sample, as summarized in Table 8, consisted of 47 participants and each of them were medical professionals.

[23] The biologist was an expert on apitherapy and was therefore interviewed to capture ideas about this practice. Apitherapy, in the first stage of the data collection, was not diffused among medical doctors.

[24] Maggot therapy is practiced in two application centers in Turkey. One of them did not agree to be interviewed and the other was not asked because of the geographical distance from the researcher.

Table 8 Summary of the Final Sample of Interview Participants

ID	Occupation	Medical Specialty, If Any	TCM Practitioner?	Professional Association Member (Other Than TMA)?	Duration of the Interview (Minutes)
1	Medical doctor / pharmacist	Biochemistry	Yes: Acupuncture, bioenergy, phytotherapy	Leads a pro-TCM; association founder of another pro-association	50
2	Physiotherapist	Physiotherapist	No	Works in TCM department of Ministry of Health	39
3	Medical doctor	Anatomy-embryology	Yes: Acupuncture, hypnosis	Member of a pro-TCM association	30
4	Medical doctor	Public health	Yes: Acupuncture	Head of TCM center at a university	45
5	Medical doctor	Pediatrician	No	No	38
6	Medical doctor	Biochemistry	Yes: Acupuncture	No	20
9	Medical doctor	Physical treatment and rehabilitation	Yes: Acupuncture, mesotherapy, cupping therapy, ozone therapy, hypnosis, phytotherapy	Member of pro-TCM association	17
10	Medical doctor	No specialty (practitioner)	Yes: Acupuncture, ozone therapy, hypnosis, bioenergy, hirudotherapy, cupping therapy, mesotherapy, prolotherapy, osteopathy	No	30
11	Medical doctor	Deontology	No	Leads an opposing professional association	33
12	Medical doctor	No specialty (practitioner)	No	Works in TCM department of Ministry of Health	34

13	Medical doctor	No specialty (practitioner)	No	Leads an opposing professional association	50
14	Pharmacist	Pharmacognosist	Yes: Phytotherapy	Leads a neutral professional association	89
16	Medical doctor	Physical treatment and rehabilitation	No	Works in an opposing professional association	25
17	Medical doctor	Deontology	No	Works in an opposing professional association	67
18	Medical doctor	No specialty (practitioner)	Yes: Acupuncture, phytotherapy	Member of a pro-TCM association	73
19	Pharmacist	Pharmacognosist	No	Leads a professional association	43
20	Medical doctor	Sports medicine	Yes: Acupuncture, prolotherapy, ozone therapy, mesotherapy, osteopathy, phytotherapy, cupping therapy	No	57
21	Dentist	None	Yes: Cupping therapy, hirudotherapy, phytotherapy	No	51
23	Medical doctor	Anesthetist / deontology	Yes: Acupuncture	Member of a pro-TCM association	55
24	Medical doctor	Biochemistry	Yes: Acupuncture	Head of TCM center at a university	32
25	Medical doctor	Physiology	Yes: Acupuncture	Head of TCM center at a university; leads a pro-TCM association	33
26	Medical doctor	Family doctor	Yes: Acupuncture, cupping therapy, ozone therapy, hirudotherapy	No	74

27	Medical doctor	No specialty (practitioner)	No	Member of an opposing professional association	70
28	Medical doctor / pharmacist	Biochemistry	Yes: Acupuncture, bioenergy, phytotherapy	Leads a pro-TCM association; founder of another pro-association	72
29	Medical doctor	No specialty (practitioner)	Yes: Acupuncture, cupping therapy, manual therapies	Member of a pro-TCM association	55
30	Medical doctor	No specialty (practitioner)	Yes: Acupuncture, cupping therapy, ozone therapy, hirudotherapy, phytotherapy,	Member of a pro-TCM association	75
31	Medical doctor	Family doctor	Yes: Acupuncture, cupping therapy, ozone therapy, hirudotherapy, phytotherapy, hypnosis, homeopathy, reflexology, mesotherapy	Worked in TCM department of Ministry of Health; graduated from faculty of medicine and TCM faculty together	74
32	Medical doctor	Emergency specialist	Yes: Acupuncture, ozone therapy, cupping therapy, mesotherapy	Leads health tourism association	74
33	Medical doctor	Physical treatment and rehabilitation	Yes: Acupuncture, ozone therapy, cupping therapy, mesotherapy, hypnosis, manual therapies	No	58
35	Medical doctor	Family doctor	Yes: Acupuncture	No	56
36	Medical doctor	Anesthetist	Yes: Acupuncture, cupping therapy, mesotherapy	TCM center practitioner at a public hospital; member of a pro-TCM association	54
37	Medical doctor	No specialty (practitioner)	Yes: Acupuncture, cupping therapy, hirudotherapy, phytotherapy	TCM center practitioner at a public hospital	53

38	Medical doctor	No specialty (practitioner)	Yes: Acupuncture, cupping therapy, hirudotherapy, ozone therapy, mesotherapy	No; works in a private healthcare center	50
39	Medical doctor	No specialty (practitioner)	Yes: Acupuncture, cupping therapy, ozone therapy, mesotherapy, phytotherapy, prolotherapy	No; educator of TCM	62
40	Medical doctor	Biochemistry	Yes: Acupuncture, cupping therapy, ozone therapy, mesotherapy	Member of a pro-TCM association	41
41	Pharmacist	None	Yes: Phytotherapy, cupping therapy	Member of a separate TCM movement	57
42	Medical doctor	Practitioner	Yes: Cupping therapy, hirudotherapy, phytotherapy	Member of a separate TCM movement	50
43	Medical doctor	Dermatology	Yes: Cupping therapy, ozone therapy, hypnosis	No	40
44	Medical doctor	Internal medicine	Yes: Acupuncture, homeopathy, ozone therapy	Leads a pro-TCM association	78
45	Medical doctor	Sports medicine	Yes: Osteopathy, prolotherapy, reflexology	No	59
46	Dentist	None	Yes: Cupping therapy, ozone therapy, phytotherapy	No	31
47	Medical doctor	No specialty (practitioner)	Yes: Acupuncture, cupping therapy, ozone therapy, phytotherapy, reflexology, apitherapy, mesotherapy, hirudotherapy, homeopathy, hypnosis	No	54

48	Medical doctor	Anesthetist / deontology	Yes: Acupuncture	Member of a pro-TCM association	46
49	Medical doctor	No specialty (practitioner)	Yes: Ozone therapy, phytotherapy	Educator of TCM; member of separate TCM movement; proponent of holistic medicine and personalized healthcare	39
50	Medical doctor	Anatomy	Yes: Acupuncture	Member of Turkish Anatomy Association	62
51	Medical doctor	Physical treatment and rehabilitation	Yes: Osteopathy, acupuncture, cupping therapy, hypnosis, hirudotherapy, homeopathy, phytotherapy, reflexology	Member of physical treatment and rehabilitation association	56
52	Medical doctor	Deontology	No	Works in an opposing professional association	41

5.3. Interviews

Interviews constituted the primary data of my research. All of the interviews were designed as semi-structured, letting the participants decide their own points of emphasis.

The research during the first stage of interviews, which corresponds to the first 21 in rows in Table 8, were more exploratory, as described above. Therefore, participants were intentionally freer to narrate the TCM integration process. More general questions like “How can you define differences between modern medicine and TCM?” were asked to encourage participants to discuss their frame of references. The first interview period was between November 2015 and February 2016. It was just after the legislation; the standards of education programs were not clear yet, and education centers, application centers, and units were not diffused well. However, even at this stage, I asked participants questions like “How do you evaluate any TCM practice?” or “Do you think it is possible to conduct scientific research related to [a particular TCM practice?” to identify the legitimacy criteria they used in evaluating TCM practices. I also asked questions about their colleagues to reveal the details of professional contestations.

However, when the second round of interviews started in October 2017, education standards for all practices had been determined, all types of centers and units had diffused, and more importantly, the number of certified medical doctors had increased (mentioned as over 3500 by a member of the Ministry of Health unofficially as of December 2017; official statistics are not available). Therefore, the main difference between the first and second stages of the study was the accumulation of data regarding TCM in the THCS.

During the second interviewing stage, both the participants and I as a researcher were more informed about the process and TCM practices. That is why, albeit semi-structured again, the second round of interviews included more specific questions like "What do think about the opposition of professional associations?" or "Do you see some of the practices as religious?" or, more specifically, "Is it possible to conduct an evidenced-based study for homeopathy or cupping therapy?". I also tried to find out how participants combined different legitimacy criteria by asking questions like "Do you see case reports as evidence for any medical treatment?" or "Do you think religious texts can guide your choice of medical treatment?".

Most of the interviews were held in the professionals' workplaces: in hospitals, private clinics, or education or application centers and in units. Therefore, I approached every interview visit as a field observation opportunity and took notes (Saldaña, 2009) during the interview or while waiting in that setting.

The interviews lasted between 17 and 89 minutes, averaging about 51 minutes. The total amount of interview data corresponds to 40 hours of digital voice recording and 747 pages of transcription.

5.4. Field Observations and Other Data Sources

I employed other data sources and field observations to provide background and historical information in verifying the interview results.

5.4.1. Field Observations

Each interview was approached like field observation as mentioned above and detailed field notes were taken during every interview. However, I visited three hospital settings specifically to observe the practices, patients, and medical doctors, as well. Details about the observed hospital settings are given in Table 9.

Table 9 Characteristics of Field Observation Settings

Observed Characteristics / Setting ID	1	2	3
Type of hospital setting	Unit	Application center	Application center
Number of certified medical doctors	1	1	2
Existence of other staff practicing TCM	1 nurse	None	None
Practices applied	Acupuncture Mesotherapy Cupping therapy	Acupuncture Cupping therapy	Acupuncture
Reason for patients' attendance	Aesthetics Pain Fibromyalgia Esophageal reflux Cupping therapy	Ear acupuncture for weight loss Obesity Migraine	Pain Breastfeeding mothers

The duration of each visit was approximately 4-5 hours. I had a chance to observe how the practices were administered to patients. In addition, I talked with the patients about their experiences. None of the hospital settings had a distinctive structure and they seemed similar to modern medicine clinics in terms of physical appearance. The sole distinct feature of the TCM application centers and the unit was the display of a table of acupuncture points and some Chinese acupuncture photos, which indicated a legitimizing of the setting by showing the acceptance and prevalence of acupuncture.

5.4.2. Other Data Sources

As other data sources, publicly available archival documents, press releases, and online and hardcopy publications were used.

Journals, especially electronic ones, provide rapid means for health professionals to publish and access current research (Crumley, 2012). In Turkey, deontological journals (the specialty of medical ethics and history of medicine) are not widespread since the area only started to capture interest among professionals very recently (as per an unstructured

interview held with a deontology doctor). Recently, some universities' deontology departments started to launch indexed journals, such as Mersin University's Lokman Hekim. Some professional associations such as the TMA also have their own journals, not specific to deontology but including general medical articles. Therefore, I chose 6 main journals and searched their archives. I will briefly explain why I chose these journals as data sources.

(1) Toplum ve Hekim is the journal of the TMA, which publishes medical articles in general. The journal was searched since the TMA is the main opponent of TCM incorporation.

(2) Hekim Postası is the journal of the Ankara Chamber of Medicine. The journal was searched since the Ankara Chamber of Medicine published several studies, releases, and books on TCM practices and their integration into the THCS.

(3) Lokman Hekim is the journal of medical history and folk medicine of Mersin University. It was searched as it is one of the limited deontology journals available online. Furthermore, some authors writing regularly for the journal are in the scientific committee of the Ministry of Health regarding TCM.

(4) Turkish Clinics Journal of Medical Ethics-Law and History was searched as it is the most widespread Turkish deontology journal according to its website.

(5) Turkish Clinics Journal of Traditional and Complementary Medicine is a new journal that published its first issue in April 2018.

(6) Ankara Acupuncture and Complementary Medicine Journal is a publication of the Ankara Acupuncture and Complementary Medicine Association. This professional association is the first in taking a role in the diffusion of acupuncture and the concept of TCM in Turkey.

Apart from these journals, other publications related to TCM were searched according to the criteria summarized in Table 10, including state reports and press releases, professional associations' press releases and publications, WHO reports and CAMbrella reports, state development plans, and minutes of Turkish Grand National Assembly. I also set up a Google alert for the phrases 'geleneksel tıp' and 'tamamlayıcı tıp' ('traditional medicine' and and 'complementary medicine'), and for the names of all regulated practices. These Google

alerts allowed me to see related publications in newspapers on a daily basis. A summary of all other such data sources is provided in Table 10.

Table 10 Other Data Sources Utilized

Source ID	Content	Available issues	Non-available issues
(1) Toplum ve Hekim (1978)	Professional association's journal on general medical issues (1978-2018)	Issues between 1978 and 2014 are available online	After 2014 not available online
(2) Hekim Postası (2011)	Professional association's journal on general medical issues (2011-2018)	Issues between 2011 and 2018 are available online	None
(3) Lokman Hekim (2011)	A public university's journal of medical history and folk medicine	Issues between 2011 and 2016 are available online	None
(4) Turkish Clinics Journal of Medical Ethics-Law and History (1993)	Academic scientific journal on ethical and historical issues of medicine	Issues between 1993 and 2016 are available online	Issues between 2010 and 2016 are available online for a fee
(5) Turkish Clinics Journal of Traditional and Complementary Medicine (2018)	Academic scientific journal on traditional and complementary medicine	Only first issue's accepted articles are available online	None
(6) Ankara Acupuncture and Complementary Medicine Journal (2014)	Academic scientific journal on traditional and complementary medicine	Issues between 2014 and 2016 are available online	2017 issues
(7) WHO reports on TCM (1978-2014)	WHO released publications about TCM including strategic plans, national policy and regulation surveys, guidelines for practices and methodologies for research, and evaluation of TCM practices	All related reports of WHO about TCM are available online via the WHO website	None
(8) CAMbrella reports (2012)	CAMbrella is a pan-European research network for complementary and alternative medicine (CAM); it released some reports about CAM prevalence in European countries, regulative status, citizen attitudes and future expectations	All related reports of CAMbrella available online	None
(9) State development plans (1963-2018)	State released development plans for five-year periods that include strategic plans for healthcare system	All state development plans available online	None
(10) Minutes of the Turkish Grand National Assembly (1908-2018)	Minutes of all general meetings	Minutes of all general meetings available online	None
(11) Publications of some professional associations, individual practitioners, and schools	TCM-related agendas, symposium reports, books	Online or hardcopy publications	None

5.5. Data Analysis

5.5.1 General Methodology of the Analysis

The analysis of the interview data was based on systematic comparison of the codes and categories [25] that emerged from the interviews with each other and with the predefined codes and categories of the literature (Strauss & Corbin, 1998). As a convention of qualitative research, an iterative approach to analysis was adopted, involving comparison of emergent categories that derived from interview data with the theory, to reach a theoretical condensation. Therefore, what were derived from interview data were verified continuously checked with the categories emerging from secondary data sources including field observations and other data sources. Emerging results were compared with the legitimacy and professional literatures, as well.

As mentioned previously, coding was used as the main analysis of this research. Conventionally, it is expected codes to be condensed towards categories which then be condensed towards themes of the any qualitative data (Berg, 2001; Miles et al., 2014; Saldaña, 2009; Strauss & Corbin, 1998). Codes are first assigned to data chunks to detect reoccurring patterns. From these patterns, similar codes are clustered together to create a smaller number of categories or pattern codes. The interrelationships of the categories with each other then are constructed to develop higher-level analytic meanings for assertion, proposition, hypothesis, and/or theory development (Miles et al., 2014, p. 80). Therefore, I condensed the results of codings procedures towards categories. However, I did not call them as themes, since the term theme reflect more emergent and grounded approach. However, I have the main themes at the well beginning of the study as legitimated practice, legitimacy criteria and legitimator professionals. Therefore, I made the coding and the following categorization of the data with keeping in mind these core themes inspired from the theory. That is why, albeit I used specific coding methods in different stages of the data analysis, the main coding I have used was theoretical coding (Saldaña, 2009) which was called as selective coding in previously (Strauss & Corbin, 1998) that includes all categories and subcategories become systematically linked with the central/core category, the one "that appears to have the greatest explanatory relevance" for the phenomenon (Strauss & Corbin, 1998). For this research, the central category is legitimation process and its possible

[25] A category is a word or phrase describing some segment of the data that is explicit (Saldaña, 2009).

dimensions of practice, criteria and professionals as the sub categories of this central category.

Therefore, in order to measure legitimation as a multidimensional process, I specifically analyzed the data to identify the analytic categories of professionals, legitimacy criteria used by them to evaluate medical treatment methods (either TCM or not) and how they construe TCM practices.

Theoretical memos (Urquhart, 2013) were written to summarize the emerging themes, observations, or ideas about the data. This facilitated finding similarities and differences among the interviews over time, which further helped to condense them.

This was a stage-based analysis and all of the stages included the general properties of the methodology explained up to this point. However, each stage had its own coding approach, which will be explained next.

5.5.2. Initial Coding of the First Group of interviews

I did not initially conceptualize the data according to the legitimacy contestation among professionals. However, it was a legitimacy study from the beginning as well. Therefore, the interviews covering the period between November 2015 and March 2016 were explorative in nature to some degree but theory driven as well. Then the data were sturucturally coded by which some conceptual phrases representing a topic of inquiry to a data that relates to a specific research aim used to frame interviews (Saldaña, 2009). In other words, I was open to emergent codes (if any) of the interviews but I had some ideas about what to look for from the data. Besides, I made an initial coding analysis at this stage by which I broke down the qualitative data into discrete parts, closely examining them, and comparing them for similarities and differences (Saldaña, 2009). These two coding prosedures enabled to code the data by considering some pre-defined codes inspired from literatures. Besides, they enabled to see emergent codes, if any.

At this point in the research, although the initial findings gave me an idea about TCM integration into the THCS, it was far from condensation because the emergent codes were not repeating. The initial findings were compared with the existing literature with an aim to reach a contextual tool for further data collection. Some emerging codes (such as religion as a legitimacy criteria), which are distinct from existing literature, or those that are in keeping

with the literature (such as normative legitimacy) and the data as well, shaped the interview protocol of the second stage data collection.

According to Saldaña (2009) and Miles et al. (2014), coding methods and be mixed and matched when needed according to the aims of the qualitative studies. Therefore, I used structural and initial coding to see initial codes and their reflections with the existing literature. Then I made an axial coding to the initial data set, to see differences and similarities (Saldaña, 2009) in this stage. There was no abstraction in this stage. The benefit of the first data collection and analysis stage was that, it drived the conceptual decisions and sampling decisions of the following steps of the study. In other words, I decided to conceptualize the legitimation as a multidimensional process including dimesions of practice, criteria, and professionals after analysis of the first group of interviews. Therefore, I collected the data (as explained in the 5.2.2 subsection) from medical professionals.

I made the final analysis of the whole data accordingly only after the second stage of interviews, which will be explained next.

5.5.3. Final Analysis of the Data

When data collection ended as of December 2017, all interview data were analyzed according process of condensing data towards some aggregate theoretical categories. The analysis included travelling back and forth between data, literature, and the emerging codes and categories, which required gradual abstraction of the raw data towards in relation with the initial conceptual framework of legitimation process.

I used every coding and analysis facility of the qualitative methods, including diagrams and theoretical memos, depending on the requirements of each analysis stage to measure my theoretical aims (as explained in the general methodology section).

The first step of the analysis constituted the aim to measure legitimacy criteria used by the participants to evaluate appropriateness of any medical treatment. Therefore, I made an initial coding to the whole data with an aim to observe with which words or expressions professionals evaluate medical treatments. Then, I made a condensation to the results to reach categories that are more abstract than the initial codes. The condensation was made with the procedures of axial coding and theoretical coding.

In the second step of the analysis, I made an attribute coding to the practices to be legitimated, namely TCM practices. Attribute coding is the notation of basic descriptive information such as: the field- work setting (e.g., school name, city, country), participant characteristics or demographics (e.g., age, gender, ethnicity, health), data format (e.g., interview transcript, field note, document), time frame (e.g., 2007,May 2005, 8:00–10:00 a.m.), and other variables of interest for qualitative and some applications of quantitative analysis (Saldaña, 2009, p. 55). Therefore, the descriptive expressions of the interview participants about TCM practices and descriptions from related literatures of TCM practices coded in this step.

In the third step of the analysis, I made an attribute coding to the participant professionals as legitimators. At this step of the analysis, I coded the expressions of the interview, which indicate the possible parts of the professional schism in the THCS, which is independent from legitimacy criteria or TCM practices. The result was analytic categories of participant professionals.

The data analyzed in these three steps were the interview data, other data sources and related literatures. The validity of the analysis was checked based on other data sources and the literature as well.

Since one of aims of the research was to identify multiplicity of legitimacy criteria, I specifically coded each interview text in the first step of the analysis, for the participant's evaluation perspective. In this step of the analysis the words any participant used to define the acceptability and applicability of any medical treatment (either TCM or not) coded specifically.

In order to find out evaluative codes, I coded each interview separately, which resulted in the huge number of codes summarized in Table 11. After the initial coding, I performed axial coding within each interview by grouping the codes according to their similarities and differences. This grouping enabled me to label every code group of each interview, which then enabled me to extract legitimacy criteria deployed by the participants. For example, the total amount of codes after initial coding for the fourth interview was 64. Codes like 'pricing -by state- will prevent abuse', 'uncontrolled sales (of medical leeches)', 'import of medical leeches', or 'illegalized money circulating in the market' were grouped according to similarity (after axial coding) under the label of 'Commercial Dimension'. As another

example, for participant Id12 the same label of 'Commercial Dimension' included codes like 'Cost Effective Evaluation', 'Reducing Medicine Costs', and 'Thinking from Budget Perspective'. As a result, each interview was condensed towards a reduced number of codes. For example, the 4th interview had 10 groups of codes and the 12th interview had 7 group of codes, which I call first-order codes.

The number of first-order codes as a result of initial coding and axial coding for each interview is summarized in Table 11. Their distribution according to the interviews is provided in Appendix E.

Table 11 Number of First-Order Codes as a Result of Initial and Axial Coding

ID	Number of Codes identified as a result of initial coding	Number of first order codes as a result of axial coding (within each interview)	ID	Number of Codes identified as a result of initial coding	Number of first order codes as a result of axial coding (within each interview)
1	58	11	29	66	14
2	58	7	30	45	9
3	4	2	31	50	12
4	64	10	32	89	11
5	30	9	33	84	12
6	23	8	35	142	12
9	34	9	36	165	15
10	7	4	37	113	15
11	43	6	38	95	11
12	47	7	39	128	11
13	53	9	40	98	13
14	65	8	41	134	12
16	53	9	42	105	12
17	109	11	43	119	13
18	85	11	44	204	15
19	66	11	45	120	16
20	63	12	46	51	11
21	67	11	47	172	19
23	65	11	48	82	14
24	55	10	49	129	16
25	62	7	50	160	15
26	57	11	51	152	16
27	44	8	52	111	15
28	53	8			

However, not all first order codes reflected the legitimacy criteria used by the professionals as mentioned before. Therefore, I made a theoretical coding to the codes to extract evaluative categories, which reflect professionals' legitimacy evaluation criteria.

For example, the code 'Value' existed in 34 of the interviews and I axially coded each of them on an inter-interview basis. For example, for participants Id41 and Id52, a TCM practice should be taken into consideration if it has 'historical value'. For participant Id36 any TCM practice is to be considered if 'regulated by the state'. For participants Id44 and Id50, 'WHO acceptance' is enough for not questioning any medical treatment including TCM practices. Therefore, first order codes condensed to the legitimacy criteria of the participants became apparent. Theoretical coding which was made to the first order codes to capture legitimacy criteria deployed by professionals. Thus, the result revealed that professionals in the sample use mainly 12 legitimacy criteria in evaluating legitimacy criteria of medical treatments (either TCM or not) which will be figured in the findings section.

In the second step of the analysis, I performed attribute coding for the regulated TCM practices. For the attribute coding of regulated TCM practices, I identified the related literature (Bicho, Nikolaeva & Lages, 2013; Broom & Tovey, 2007) and interview excerpts of participants in determining the dimensions of: (1) traditional (TM) versus complementary (CM) medicine, which means whether or not any TCM practice is embedded in the local culture (for the former) or not (for the latter); (2) requiring drug treatment that includes injection or taking any medical drug or substance; (3) having a distinct core philosophy, which means that a TCM practice has a distinct epistemological ground and is based on a specific theory other than a scientific paradigm; (4) having a historical background, which means either that a TCM practice has been recorded in historical medical texts or that it experienced a contested historical process over a period of 100 years. Finally, I added a fifth dimension as being mentioned in religious texts, which means that a TCM practice is referred to in any religious source, such as hadith texts, passages in holy books, etc. I added this attribute since some TCM practices are accordingly contextualized in Turkey.[26] Participant professionals construe the TCM practices as a heterogeneous bundle. According to results of coding each TCM practice according to these dimensions, almost each regulated TCM practice possess different configurations of the above dimensions as will be explained in the findings section.

[26] Individual explanations of each regulated TCM practice in terms of these attributes are explained in Appendix D, where definitions and historical information of TCM practices are explained.

I checked the validity of the attribute coding of the regulated TCM practices both from other data sources and by personally asking a deontologist participant. In order to discuss the validity of this coding step, I made email correspondences with the deontologist participant. Table 15 summarizes the attribute coding results of regulated TCM practices which will be explained in the findings chapter.

The third step of the analysis involved the attribute coding of the participating professionals, during which I used both the literature and the data. In this step of the analysis, I tried to reach some analytic categories of professionals which means that professionals share similar characteristics within the group but separated from the other group. In identifying these categories, I coded the interview excerpts of the professionals in which they define or explain the professional schisms, division in the THCS. Those divisions are driven neither by TCM practices nor by the legitimacy criteria professionals deploy. The participant professionals categorized to some professional profiles at the end of this theory driven coding analysis. Professional profiles together with other findings explain the contested and multidimensional form of legitimation process which will be explained in the next chapter.

The findings section will fully illustrate the results of the analysis with related excerpts and summarize the results. Before that, I will briefly explain the analysis of the other data sources.

5.5.4. Analysis of Other Data Sources

I developed some lists of key words and phrases that can be assumed as institutional vocabulary (Suddaby & Greenwood, 2005) in studying TCM integration into the THCS and professionals' legitimacy claims. However, each data source has its own system to use in such searches and unique availability of the issues as well. Therefore, I searched other data sources according to the criteria summarized in Table 12.

Table 12 Analysis of the other data sources

Source ID	Searched For	Results / Data
(1) Toplum ve Hekim (1978)	Keyword-based research available for the online issues; a search was done for 13 related keywords: complementary, traditional, tradition, traditions (both Turkish and English), alternative, local, Anatolian folk, medical education, religion, history, market, tourism	183 articles found, 28 of which were extracted by reading abstracts
(2) Hekim Postası (2011)	All issues between 2011 and 2018 were searched by whole counting method	9 articles extracted
(3) Lokman Hekim (2011)	All issues between 2011 and 2016 were searched by whole counting method by reading abstracts of articles	44 articles extracted
(4) Turkish Clinics Journal of Medical Ethics-Law and History (1993)	All issues between 1993 and 2010 were searched by whole counting method by reading abstracts of articles	55 articles extracted
(5) Turkish Clinics Journal of Traditional and Complementary Medicine (2018)	All articles searched by whole counting method	7 articles extracted
(6) Ankara Acupuncture and Complementary Medicine Journal (2014)	All articles between 2014 and 2016 searched by whole counting method	15 articles extracted
(7) WHO Reports on TCM (1978-2014)	All reports between 1978 and 2014 searched	16 reports extracted
(8) CAMbrella reports (2012)	All reports as of 2012	6 reports extracted
(9) State development plans (1963-2018)	The field of healthcare was searched within 10 development plan texts	Only in the last (10th) state development plan did the notion of 'Complementary Medicine' include goals of control, regulation, research and education support, and integration
(10) Minutes of the Turkish Grand National Assembly (1908-2018)	Minutes were searched for the terms 'traditional medicine', 'complementary medicine', 'alternative medicine', and the names of all practices	Two minutes were extracted including names of some practices in 2013
(11) Publications of some professional associations, individual practitioners, and schools	Read based upon categories that emerged during the analysis	1 agenda, 3 symposium reports, 3 books

6. FINDINGS

At the beginning of this study, I proposed that legitimation may be a multidimensional process which involve legitimated practices, legitimacy criteria and professionals as legitimators albeit studied as unidimensional by the extant literature. Besides, the process might be more complex than previous conceptualizations since those dimensions may interact with each other.

According to the findings of the analysis, the practices to be legitimated in the process of TCM integration to the THCS, not a single form of an innovation or a new venture as studied by the majority of the previous studies, but a bundle of some practices legitimated. Besides, some of the TCM practices in this bundle constitute an outcast nature, which means that, they have a historical background, which drives the legitimation process.

Regarding legitimacy criteria deployed by the legitimators, namely professionals in this study, there is multiplicity of criteria, which constituted the scenario of contested legitimacy.

Finally, there seems a professional schism between professionals of THCS, which is not directly related with the TCM integration to the field albeit driving the process.

Therefore, there are two main findings of this study; First, the legitimation process is a complex multidimensional process, which is driven by practices, criteria and professionals. Second, legitimation is unfolding as contestation, which is driven by the interaction among these dimensions.

In this chapter, I will explain the empirical findings of the study in the legitimacy criteria, practices and professional schism subsections. Those sections will exemplify the results of the analysis made to the data with the related interview excerpts or supportive and descriptive data from other data sources. Then I will end the chapter which explaining how the process of legitimation is unfolding with these three dimensions in a contested and complex space. This section will involve narrativization of the interaction among the three dimensions of legitimation process. The main finding of this last section is that, practices, criteria and professionals interact with each other thus there is not a predictive relation among them.

6.1. Legitimacy Criteria

At the beginning of the study, I proposed the existence of multiple legitimacy criteria for the legitimation of TCM into the THCS. The legitimacy criteria deployed by the participant professionals found as a result of the theoretical coding, which I performed to the initial codes of the interview data. The theoretical coding included extraction of the excerpts which involve direct evaluation of any medical treatment (including TCM practices) by the participant as good or bad; appropriate or inappropriate or applicable or not. In other words, according to the participant professionals of the sample, any practice to be accepted as a medical treatment (or to be denied from being medical treatment) has to possess or has to satisfy specifically determined twelve (12) legitimacy criteria. These criteria are summarized in the Table 13.

Table 13 Legitimacy Criteria

Legitimacy Criteria *	**Corresponding Legitimacy Dimension**	**Participant Numbers ****
Harmless (treatment)	Normative	23
Effectiveness of the results (of the treatment)	Normative	34
Safety	Normative	3
Validity	Normative	29
Doctors' choice of treatment	Normative	2
State's regulatory recognition	Regulative	40
WHO acceptance	Regulative	4
National	Moral	9
Application of the Prophet	Moral	3
Philosophy of the treatment	Moral	9
Economic value	Pragmatic	14
Expensive / Cheap for State Budget	Pragmatic	10

* As a result of theoretical coding made to the 1st order codes
** Number of participants who deployed this criterion

These legitimacy criteria are explicated independent from TCM practices and professional divisions by the participants.

For some participants any practice has to be harmless to the patient to be accepted as legitimate and to be applicable. For some others, approval of WHO, as the global health authority is enough to evaluate any practice to applicable to the patient. Therefore, some criteria in this list are unidimensional, which involve an exact meaning. These are; Harmless, safety, doctor's choice of treatment, WHO acceptance and State recognition, application of the prophet, expensive/cheap for the state budget criteria.

On the other hand, some legitimacy criteria have dimensions. For example, Effectiveness of the results explained by some participants subjectively, by some others objectively. To exemplify, for some participants (such as Participants ID #2, 5, 6, 16, 17, 19) effectiveness of any medical treatment has to satisfy necessities of objective scientific study. Therefore, to be accepted as legitimate, it has to be proven by a scientific evidence. However, for some others, subjective evaluations of the patients about results of the treatment (which is called as subjective wellbeing by some participants such as participants ID # 17, 36, 38, 50, 51) is a base for evaluating any practice as effective.

From this perspective, validity of the medical treatments (including TCM practices) proxied to amount of publications (such as participants ID #25, 40 and 47) or to the documentation of the clinical observations by some participants (such as participants ID #23, 36 and 37). That is what made validity a multidimensional legitimacy criterion as well.

Similarly, some participants as having historical or folkloric value (such as participants ID # 17 and 27) describe the criteria of being national. On the other hand, for some participants it reveals dependency of the practice to the Turkish historical background (such as participants ID # 1, 18 and 23).

Philosophy of any treatment (if any) is divided into two according to the epistemological drive of any medical treatment, which means that, the source of the knowledge of that medical practice. For example, for some participants, the driving knowledge of any medical treatment should depend on the scientific paradigm (such as participants ID # 13, 16, 23) to be accepted as a legitimate treatment. Whereas for some others the driving knowledge of any medical treatment can depend on any other knowledge sources which cannot be explicated by scientific paradigm (such as homeopathic knowledge. See Appendix A for the explanation of the practice) to accept that treatment as a legitimate practice.

Finally, some participants (such as ID # 32) describe economic value of any medical treatment as its brand value. Some participants describe it as being a saleable object (such as ID # 18).

At this point, I have to explain that not every legitimacy criterion deployed by each corresponding participant in an approval manner. Some of the legitimacy criteria used to delegitimize any medical treatment including TCM practices. For example, WHO acceptance of any medical treatment in its lists is enough for some participants. However,

WHO is defined as inappropriate criteria of legitimation by one participant indicating the organization as 'imperialist' (such as ID # 49). Similarly, application of the prophet constitute legitimacy for some professionals (such as ID # 10, 37 and 42). But for some others it is nothing to the with medical treatments (such as ID # 1, 16, 23). The same situation exists for the criteria of economic value and state's regulatory recognition as well. Therefore, not every legitimacy criterion deployed for affirmation purposed. Instead, they used for disapprobation by some participants.

The second column of the Table 13 views corresponding legitimacy dimension of each legitimacy criteria from literature. Therefore, it can be inferred that majority of the participant professionals deployed normative legitimacy, specifically emphasizing that any medical treatment should be effective, harmless, safe and valid to be accepted as legitimate. Some of the participants declared that according to act of Law 1960, medical doctors are free to choose the appropriate medical treatment for their patients. Therefore, what is chosen by them is legitimate (such as Participant ID #40 and ID #49). Regulative legitimacy is seen as the most deployed legitimacy criteria. However, not in a positive manner by all participants. Few of them deployed moral legitimacy dimensions by emphasizing some authentic values of the practices. Pragmatic legitimacy in terms of economic concerns deployed by half of the participant professionals in some manner according to the results.

The examples of interview excerpts for each legitimacy criteria can be seen in the Table 14.

Table 14 Examples of Interview Excerpts for legitimacy criteria deployed by the participant professionals

Legitimacy Criteria	Example Excerpt
Harmless (treatment)	For example, we have some rules in medicine. Since the era of Hippocrates, the first rule is that you must not harm the patient. If [with a practice] the possibility of being harmful is higher than being beneficial, doctor has to give up that practice. That is our first rule. (Participant ID #5)
Effectiveness of the results (of the treatment)	Subjective: [TCM practices] are not proved very easily. However, we have positive feedback taken from patients in our hands. That is why we think that, especially for traditional practices, the 'response' rate is more powerful than the 'evidence' rate […] Yes, we need evidence since we cannot isolate our cases to progress. However, TCM doctors leave other specialties and become more motivated because of the positive feedback and responses from patients. (Participant ID #37) Objective: TCM practices are methods that do not have [the support of] scientific study. The existing studies [on TCM practices] are far from being valuable in terms of their methodology […] When we review TCM studies, we see that their methodologies are not randomized controlled trials, their cases and observations are deficient, it's not enough […] The medicines we use are proved as effective instead. (Participant ID # 16)
Safety	Well, if we define medicine as a circle, any of the TCM practices can penetrate into this circle only if they satisfy some requirements. What are these requirements? Efficiency and safety. Any treatment that claims to be medical can penetrate into the circle if it is efficient, safe, and has minimum side effects. Therefore, we have to talk about principles, not about names. (Participant ID #48)
Validity	Publications: Acupuncture is quite different from others [TCM practices]. We gave over 1000 publications to the Ministry about acupuncture. Well, you can ask the question that, does the number of publications indicate that it is a good practice? Ofcourse not every publication is in a positive manner, not each of them shares similar results. However, it can be accepted as an indicator that, the practice is available for a scientific study. If you can apply some statistical methods to study any practice, it means that it is a medical treatment (Participant ID #23). Documentation: It is difficult to apply [scientific study] for osteopathy or prolotherapy. It is difficult to design the study […] But we have to document our results of patient cases, that is our deficit. (Participant ID #45)
Doctors' choice of treatment	In the end, healing is the duty of the doctors. It is important by which healing method you treat your patients. The doctor can decide which treatment method is appropriate according to Law 1219. In our country, everything depends on permission. Indeed […] doctors can decide to use hacamat if they find it available (Participant ID # 40).
State's regulatory recognition	If it was not among the Ministry's list, would I go learn hacamat, for example? You can ask me this, it is important. I cannot say 'yes' directly to this question, indeed, because, to be honest, the fact that I saw hacamat in the Ministry's list pushed me to learn hacamat. […] I may not have learned if not included in that list (Participant ID # 36).
WHO acceptance	It is a fact that the WHO published an indication list for acupuncture, which includes the availability of acupuncture as the first treatment method. It is important. Is the WHO doing something unscientific? No, these aspects have to be considered (Participant ID # 29)

National	Historical: Traditional medicine has a history of over 1000 years. It is a medicine that we inherited from our antecedents and was developed by the Ottomans. Traditional medicine has documented sources over 1000 years old. It is a healing system, applied and taught in Europe and other parts of the world as well. Today modern medicine has only 100 years of history and it excludes traditional medicine. This is not acceptable to me (Participant ID # 31). Folkloric: TCM is within the scope of folklore, it has folkloric value. Yes, in some countries there are institutes or platforms for some of these practices. For example, there homeopathic platforms in the USA […] Ultimately, they have folkloric value to me, they can be part of folkloric studies. […] Anyway, I can tolerate them unless they are harmful to anyone and as long as they are under state control (Participant ID # 27).
Application of the Prophet	Affirmation: If [the Prophet] advised it, this will prove the reliability of that method. Well, in our eyes, in believers' eyes. For the unbelievers, they do not accept the word of the Prophet, but they rely on historical background and rely on European acceptance as well (Participant ID # 42) Disapprobation: Well, hacamat is a practice that is not related to [Islam] since has been applied long before the religion diffused. When we look at its documented history it goes back 5000 years, nothing to do with religion (Participant ID # 47)
Philosophy of the treatment	When we take these practices [in regulation] we break their ties with the theories, philosophies on which they constructed everything. For example, we take acupuncture as a technique, just putting needles to some points. Indeed, there is a big yin-yang theory behind this. Similarly, Ayurveda has a big philosophy. If you take them as techniques solely, breaking them away from their theories, then there will not be any difference between leeches and Ayurveda. Or it becomes like boiling mint and lemon. Then the problem becomes: are these really medical treatments? (Participant ID # 11). For example, it is advised not to perform hacamat during the menstrual period, and I obey this rule. I always [follow the days appropriate for hacamat according to the Islamic calendar]. […] I try to apply it when I am ritually clean and I pray while applying it to protect myself. […] The hadith can be accepted as a verbal, reliable source of information, which we can use in the TCM field. […] The hadith give us information about an application process of 1400 years old. It is a reliable source of information (Participant ID # 37).
Economic value	Sessions are expensive, products are expensive, it's a huge market. There will be advertisements, sale of the products, training programs, certificate programs. The ones who give certificates will gain financially. […] Doctors will settle on a center and meet with patients continuously; they are gaining too much in the market. […] Well, you know the cancer patients and phytotherapy. Excessive amounts are being earned [from cancer patients]. (Participant ID #16).
Expensive / Cheap for State Budget	If we can produce herbal drugs we can export them as well. Now we sell them without processing and thus sell them very cheap. But we [as a country] can become a center in the world. People can visit our country for treatment. In addition, we can use what we produce instead of imported medicines. Acupuncture needles are very cheap, which will not be costly for the state. The only cost will be the one paid to the doctor; less will be paid to the importers. However, we pay much more for the medicines we import. As I see it, diffusion of acupuncture will compensate almost half of the medicine expenditures of the state in one year (Participant ID #1).

The second dimension of the legitimation process was legitimated practices, which will be explained in the next subsection.

6.2. Practices

At the beginning, I argued the possibility of legitimated practices which constitute a heterogeneous bundle instead of a single form of practice as explained by the extant literature. TCM practices are accepted as heterogeneous in terms of various dimensions according to the related literatures (Bicho et al., 2013; Broom & Tovey, 2007; Eisenberg et al., 1993; Mizrachi et al., 2005). Findings of this study revealed the similar result in a way that, participant professionals defined regulated TCM practices in THCS as a heterogeneous bundle. Therefore, it became apparent that, in legitimating TCM practices, the process involves legitimation of discrete entities of legitimation. In the second step of the analysis, there are two sub-steps. First, I identified related dimensions according to which regulated TCM practices will be codded. Second, I made the attribute coding to each TCM practice on these dimensions.

In identifying different dimensions, which define distinctive aspects of the legitimated TCM practices, not only interview excerpts, but also reports of the global organizations such as WHO and other data sources which were explicated previously in this text, were used. Then, practices coded accordingly. For practices, it was an attribute coding procedure, thus it involved extraction of descriptive expressions and words, which describe differences of the legitimated TCM practices. On the other hand, not every dimension belongs or explanatory for every TCM practice as well.

The first dimension is inspired from the classification of WHO, as explained in the Chapter 3 [27.] WHO classified TCM practices as a heterogeneous bundle which include traditional practices and complementary practices. This distinction between regulated TCM practices in terms of being traditional and complementary expressed by the participant professionals as well. For example:

> The legislation text does not involve any explanation about which one of these practices is complementary or which one is traditional. This is a big deficiency. […] They must be defined according to this categorization and then, certifications should start (Participant ID # 19).

Another participant expressed that:

[27] The sub section 3.2. Definitions of Traditional and Complementary Medicine.

> The [legislation] text involve both acupuncture, hypnosis, leeches and homeopathy at the same time […] To me, regulated practices are different from each other. For example, neural therapy[28], which is applied with an injection procedure of a special medical solution, which is used in modern medicine as well. Is it traditional or complementary, I put a question mark here (Participant ID # 51).

Participants declared their concerns over the distinction of the regulated practices in terms of being traditional or complementary to criticize the manner of the regulation. Therefore, they question the appropriateness of the state recognition from this perspective.

The second dimension is about the requirement of drug treatment that includes injection or taking any medical drug or substance. Some of the TCM practices require such injection procedures such as mesotherapy, prolotherapy, ozone therapy and apitherapy (as the definitions of the practices explicate which can be seen in Appendix D). For some participant professionals such injections of drugs resemble to the modern medicine applications thus, contrast to the general philosophy of the TCM application. From this perspective, self-healing system of the body without any outsiders' prevention is accepted as the general philosophy of the TCM application. For example:

> I like acupuncture, since it does not have any side effects, because you do not give any medicine to the patient, because it is in harmony with the philosophy. The philosophy of Chinese medicine, in harmony with the self-healing of the person. However, when you give something from outside, for example the medicine in mesotherapy, it is modern medicine again (Participant ID # 35).

Some of participants apart the injector based TCM practices from the bundle, and blame them as being harmful to the patients and being regulated with financial concerns:

> [Regulators] present them as complementary, like marketing tools. There are too many practitioners applying mesotherapy. […] They are gaining too much cash from mesotherapy. What are its benefits? It is melting oils, increasing hair, they say. I have not observed these results in myself, indeed. I have a certificate and I applied it to myself as well. […] They think they are not harmful, but I think these are traumatic treatments, not innocent (Participant ID # 50).

[28] Neural therapy is not among the regulated practices whereas it posses similar idea of stimulating the body with some injections to mobilize self healing system.

The third dimension is about having a distinct core philosophy, which means that a TCM practice has a distinct epistemological ground and is based on a specific theory other than a scientific paradigm. Mizrachi et al., (2005) explained the philosophical dimension of TCM practices bundle, which is lack of a unified, formalized and standardized body of knowledge, as well as having some underlying epistemological assumptions such as health and illness are not based on causal factors but are caused by an imbalance between opposing energy forces, and usually claim a holistic orientation (p.25). However, not each TCM practice possess such a philosophical base. WHO (2014) described that specifically traditional practices as the sum total of the knowledge, skill, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness (p. 15). Therefore, the basis of knowledge sources other than scientific paradigm is mentioned as a descriptive attribute of traditional practices. However, such a description is not attached to the complementary ones. This is expressed by the participant professionals as well:

> Complementary medicine is divided into two. There are those [practices] that have a philosophy and those that do not. Acupuncture and homeopathy have a philosophy. There are some others arising near modern medicine, such as prolotherapy, mesotherapy […] (Participant ID # 44).

The participant of the above excerpt (ID # 44) made this distinction among regulated TCM practice to pinpoint his acceptance that, TCM practices which have a distinct philosophy requires some art and talent of the practitioner whereas others do not. To him, philosophy owner TCM practices can not be taught properly with a formal education but others can be.

The fourth dimension, which emerged after attribute coding of the TCM practices, is having a historical background, which means either that a TCM practice has been recorded in historical medical texts or that it experienced a contested historical process over a period of 100 years. Here again, WHO (2014) expressed that traditional medicine has a long history (p.15). But there is not such a description for complementary ones. That is why, I coded historical background as an attribute which separates regulated TCM practices' bundle. Data from other sources supported that some TCM practices have a long history such as acupuncture (Geçioğlu & Geçioğlu, 2014), music therapy (Birkan, 2016) and cupping

therapy (Qureshi et al., 2017). On the other hand, some others such as prolotherapy (Hakala, 2005) invented as complementary to some modern medicine treatments and is not dated back to the historical documents.

Some TCM practices experienced a historical process of denigration from healthcare systems (as explained in some country examples sub section of Chapter 3). For example, Chiropractic and Osteopathy struggled to be legitimized in some contexts, thus possess a controversial history which indeed interact their legitimation in THCS.

Historical background of some TCM practices has been expressed as an attribute by the professional participants as well:

> In my opinion, if any practice heals people and has historical origin, it is okay. We see many emergent therapies in recent years; I do not accept them. Treatments have to be fixed with solid experience. That is to say, any treatment has to possess an unblemished and solid historical background (Participant ID # 31).

The participant of the above excerpt does not accept emergent therapies without mentioning any name but give value to the ones which have a historical background.

Finally, I added a fifth dimension as being mentioned in religious texts, which means that a TCM practice is referred in any religious source, such as hadith texts, passages in holy books, etc. For example, the use of honey with apitherapy has been documented in several religious texts including the Veda (a book of Hindu scriptures) and the Bible, and 4000-year-old tablets record the use of honey in ancient Sumer (Ahuja & Ahuja, 2010). The Prophet Muhammed is also believed to have advised usage of honey as a therapy (Qureshi et al., 2017).

Specifically, I added this attribute since some TCM practices are contextualized in Turkey according to this attribute. The most debated TCM practices in terms of their religious base are cupping therapy (namely hacamat) and hirudotherapy (usage of medical leeches) [29].

[29] Although hirudotherapy is not mentioned in any religious texts according to my research, in terms of categorization it is linked closely with cupping therapy because these two practices share the same core philosophy of bloodletting – the removal of bad substances or peccant humors (Baran, 2013; Hyson, 2005).

> [TCM legislation] was regulated too late. It is Sunnah of our Prophet. We do not have the liberty to question this. I say this only for hacamat, of course. We can't question it (Participant ID # 10).

The participant of the above excerpt strongly defends the regulation with referring to the religious dimension of one practice. Some participants refer to the hadith texts to emphasize Prophet's word about phytotherapy such as his advises to use black cumin (such as participant ID # 2, 42).

As a result, both the interview excerpts and related literatures reveal that regulated TCM practices in THCS does not form a homogenous group of some medical treatments. Instead there is a heterogeneous bundle of practices which have different attributes according to the five main dimensions. Table 15 summarized the results of the attribute coding explicated in this section.

Table 15 Attribute Coding Results of the Regulated TCM practices

Practice	TM/CM	Requires Drug Treatment	Has a Distinct Core Philosophy	Has Historical Background	Mentioned in Religious Texts
Acupuncture	TM/CM	No	Yes	Yes	No
Apitherapy	TM	Yes	No	Yes	Yes
Homeopathy	CM	Yes	Yes	Yes	No
Music Therapy	TM	No	Yes	Yes	Yes
Cupping Therapy	TM	No	Yes	Yes	Yes
Hirudotherapy	TM	No	Yes	Yes	Yes*
Prolotherapy	CM	Yes	Yes	No	No
Mesotherapy	CM	Yes	Yes	No	No
Ozone therapy	CM	Yes	No	No	No
Osteopathy	TM/CM	No	Yes	Yes	No
Reflexology	TM/CM	No	Yes	Yes	Yes
Chiropractic	TM/CM	No	Yes	Yes	No
Maggot Therapy	CM	No	No	Yes	No
Phytotherapy	TM/CM	No / Yes *	Yes	Yes	Yes
Hypnosis	TM/CM	No	Yes	Yes	No

* See the explanation in Appendix D.

The final dimension of the legitimation process, which I proposed, was professionals which will be explained in the next sub section.

6.3. Professional Schism

In the conceptual framework, I proposed that there may be a professional division which is unfolding a legitimation process. Although there are some exceptional studies, extant literature approach professionals as a homogenous group who foster normative legitimacy.

The literature about legitimacy and professionals seems silent about potential professional schisms as driver of the legitimation and divisions as results of a legitimation process. In this section I will exemplify the results of the study which reveal how professionals categorize themselves or their colleagues in their field which reflect professional schism in the field that is not driven by TCM integration process but is unfolding the process. Therefore, the categorization I made as a result of coding some attributes of the professionals is analytic in nature.

According to the attribute coding results of the professionals there are 3 main analytic categories which are expressed by professionals to define their own positions or positions of other professionals in the field. Those are being (1) Holistic or Materialist, (2) Market oriented or not Market Oriented, (3) Socialist / Nationalist/ Religionist/ Moderate.

(1) Holistic[30] or Materialist

The first categorization of professionals made according to their expressions, which define how they approach to the healthcare provision. Being holistic defined in two ways by the participant professionals. First, some of the professionals in the sample defined themselves as being holistic, taking into consideration human body as whole including physical and non physical aspects of it (such as participant ID # 1, 26, 30, 36) . Second, some participants defined themselves as being holistic, merging modern medicine techniques with those of the TCM practice they used (such as participant ID # 1, 24, 50, 51, 47). For example, one of the participants declared that:

> I am a holistic medicine doctor. I believe that the only medical approach is holistic medicine. In Turkey, the most similar approach to the holistic medicine is traditional and complementary medicine. TCM practitioner doctor got modern medicine education thus they can merge these two approaches […] The legislation ensured this but it is not enough. Medical industry requires fragmented and divided doctor mind. That prevents doctor's holistic perspective (Participant ID # 49)

On the other hand, some professionals define the opposite of being holistic with expressions like being materialist (such as such as participant ID # 1, 18, 26) or thinking in a particularistic or overspecialized way. According to these definitions, holistic oriented

[30] See Appendix A for the dispute over terms that the term holistic is used interchangebly with integrative and integrated in the literature. That is what participants did as well. Therefore, I used the term holistic for the other synnoyms they prefered.

participants blame others not to take into consideration human psychology, or blame them with missing some aspects of diagnosis or treatment.

On the other hand, some professionals define themselves as materialist and express that:

> I believe the necessity to look in a materialist way. The progress [in medicine field] occurs only if the approach is based on the material manner. […] Medicine has to be materialist (Participant ID # 13)

However, the name being materialist does not reflect ignorance of the human body as whole. Instead, it reflects the denial of the integration of TCM practices with modern medicine and denial of non-physical aspects of the human body. For example, the professional of the above excerpt finds it 'archaic' to deploy TCM practices since modern medicine is developed enough to satisfy the healing needs of people. Besides, to her, any psychological process of the human body can be explained with material processes.

According to the attribute coding results of the professionals in terms of being holistic or materialist; three of them used the word being materialist for themselves. 22 of the participants expressed themselves as being holistic. Those are Participant ID # 1, 3 ,4 ,6 18, 20, 23,24,26,29,30,32,36,37,38, 39, 40, 44, 45, 47,48 and 51).

(2) Market oriented / Not market oriented

According to the attribute coding results, when the entire sample is considered, 22 of the participants have private clinics and all of the private clinic owners earn money from TCM except one. Viewing this result from another perspective, 21 of the TCM practitioner participants possess a private clinic where they earn money by applying TCM. Therefore, there is only one exception among TCM practitioners of the sample who is not earning money from TCM. That participant is a dentist who has a private clinic where she does not perform any TCM practices, although she is a TCM practitioner elsewhere.

There are nine more TCM practitioner participants in the sample who earn money from TCM but do not have a private clinic. Among these nine participants, two of them are pharmacists who apply phytotherapy. One of these pharmacists is also an advocate of an independent TCM movement based on humoral pathology. Five of the practitioners who do not own private clinics are members of university TCM application centers and perform TCM practices in those centers. Two of them practice unofficially (but do have certificates) and earn money independently.

Seven of the TCM practitioners in the sample do not earn money from TCM practices. Four of them apply these practices in public hospitals free of charge. Three of them have certificates and are advocates of the integration process but practice only for their acquaintances free of charge.

Table 16 Summary of the participants in terms of their attribute coding for the financial concern

ID	Occupation	TCM Practitioner?	Earning Money from Any TCM Practice?	Has Private Clinic?
1	Medical doctor / Pharmacist	Yes	Yes	Yes
2	Physiotherapist	No	No	No
3	Medical doctor	Yes	Yes	No
4	Medical doctor	Yes	Yes	No
5	Medical doctor	No	No	No
6	Medical doctor	Yes	Yes	Yes
9	Medical doctor	Yes	Yes	Yes
10	Medical doctor	Yes	Yes	Yes
11	Medical doctor	No	No	No
12	Medical doctor	No	No	No
13	Medical doctor	No	No	No
14	Pharmacist	Yes	Yes	No
16	Medical doctor	No	No	No
17	Medical doctor	No	No	No
18	Medical doctor	Yes	Yes	Yes
19	Pharmacist	No	No	No
20	Medical doctor	Yes	Yes	Yes
21	Dentist	Yes	Yes	Yes
23	Medical doctor	Yes	No	No
24	Medical doctor	Yes	Yes	No
25	Medical doctor	Yes	Yes	No
26	Medical doctor	Yes	Yes	Yes
27	Medical doctor	No	No	No
28	Medical doctor / Pharmacist	Yes	Yes	Yes
29	Medical doctor	Yes	No	No
30	Medical doctor	Yes	Yes	Yes
31	Medical doctor	Yes	Yes	Yes
32	Medical doctor	Yes	Yes	Yes
33	Medical doctor	Yes	Yes	Yes
35	Medical doctor	Yes	No	No
36	Medical doctor	Yes	No	No
37	Medical doctor	Yes	No	No
38	Medical doctor	Yes	Yes	Yes
39	Medical doctor	Yes	Yes	Yes
40	Medical doctor	Yes	Yes	Yes
41	Pharmacist	Yes	Yes	No
42	Medical doctor	Yes	Yes	Yes
43	Medical doctor	Yes	Yes	No
44	Medical doctor	Yes	Yes	No
45	Medical doctor	Yes	Yes	Yes
46	Dentist	Yes	No	Yes

47	Medical doctor	Yes	Yes	Yes
48	Medical doctor	Yes	No	No
49	Medical doctor	Yes	Yes	Yes
50	Medical doctor	Yes	Yes	No
51	Medical doctor	Yes	Yes	Yes
52	Medical doctor	No	No	No

None of the participants, who are not TCM practitioners, do not earn money from any TCM practices, as expected. Besides, none of them have private clinics. Ten participants are not TCM practitioners in the sample. Two of them working for the Ministry of Health. Eight of them are professionals from different areas of expertise.(Table 16 summarizes participants in terms of their financial concern)

The majority of medical doctors I interviewed admitted that integration of TCM provides market opportunities for their field. However, not every practitioner of TCM found himself or herself market oriented:

> In general, our colleagues who practice TCM in their private clinics are family doctors and they attend these certificate trainings with financial concerns. They want to get a certificate as soon as possible and tend to practice with economic concerns. It is very different for me. It was a learning process for me (Participant ID #33).

On the other hand, some of the participants welcome earning money from TCM practices and approach to this nascent field not differently from any other medical treatment method, which provides them income as well. They feel very comfortable since they solve problems of patients and get paid for it, which they find very ethical and legitimate:

> No doubt, anyone prefers to gain money in return for his or her efforts. Of course, doctors live off healing people. I am working in this clinic and provide jobs for 10 additional workers; thus, I have to earn money. There is nothing more natural than this. (Participant ID #47).

Finally, there are participants who define themselves anti-market oriented, since they accept gaining money from healing people is illegitimate and healthcare provision is a human right not a saleable object (Such as participants ID # 13, 17, 16 and 52) regardless of which treatment method used.

(3) Socialist / Nationalist/ Religionist/ Moderate.

The last categorization of the participant professionals extracted from the expressions they have used about their political or ideological standpoint.

For example, some professionals define themselves as being socialist and expressed that:

> Socialist medicine approach requires evaluating the person with his or her environmental conditions. By the environmental conditions I mean, whether or not that person has got a regular job, working under the minimum wage, living in his/her own house, dietary applications etc. All these determine his/her healthcare, no doubt. […] Therefore, healthcare must be accessible by everyone […] Healthcare is a human right. (participant ID #13)

Some professionals declared the importance of nationality national sources and national knowledge to them (such as participants ID #1, 18, 23, 38) which determine their approach to the healthcare system.

> "In this [Turkish] culture, there have been many people engaged in this [TCM]. Now we are retrospectively examining their methods. […] As a result, a new medicine will emerge. […] It will be a new synthesis. […] In the future, we [Turks] will be the leading service providers" (Participant ID #1).

Some professionals defined themselves as being religionist (namely, Muslim) (such as participant ID # 26, 33, 37 and 42) thus expressed that this situation effects their approach to the healing people or medical treatments. For example:

> If [the Prophet] advised it, this will prove the reliability of that method. Well, in our eyes, in believers' eyes. For the unbelievers, they do not accept the word of the Prophet, but they rely on historical background and rely on European acceptance as well (Participant ID # 42).

Finally, there is a category of professionals who do not care about political and ideological distinctions and act in a moderate view. Such as:

> Well, about the religious side, I don't ever care about it. However, of course I pay attention to it as patient psychology is very important. Practicing [hacamat] on religious days that are the 17th, 19th, 21st, 23rd, and 25th days of the [Islamic] calendar are [the religiously appropriate] hacamat days. Besides, Monday, Tuesday, and Thursday are days you can apply it. I do not know the reason for these days and I have not searched for it because, seriously, the religious side does not interest me. However, if any patient wants to obey this, I schedule the date accordingly. Only if the patient demands it. Otherwise, it makes no sense to me. I do my treatments regardless (Participant ID # 30).

According to the attribute coding results, all of the participant professionals declared their approval towards science. In other words, healthcare system has to be scientific for all participants in the sample. There is not any participant who declared opposite of this claim.

> Indeed, nothing has a mystic side. Science can explain everything, but it just has not all been explained yet. There can be nothing-unscientific [in medicine] (Participant ID #44).

However, the contruals of science differs among professionals, which made them divided in this point.

The aim is to figure out the professional schism in the THCS, not to extract all possible professional types in this stage of the analysis. Therefore, categorization of professionals in this subsection reveal some professional profiles, which are not exhaustive but prevalent in the sample. In the next subsection, I will explain how legitimation is unfolding, driven by legitimacy criteria, practices and professionals' schisms in a complex and contested space.

6.4. Legitimacy is a contested process

In the previous sections of this chapter, I exemplified the results emerged from the empirical context. The results figured out that, legitimation process is more complex than it is expected. Legitimation is multidimensional process which involve some dimensions which are multiple among themselves either. In other words, there is multiplicity of legitimacy criteria deployed by the legitimators, legitimated practices constitute a heterogeneous bundle, some of them are outcast in nature, and there is a schism among legitimator professionals who evaluate the legitimacy of the practices.

On the other hand, the main thing, which makes legitimation as a continuous contested process, is not the existence of such multidimensionality or multiplicity. Instead, there are some interactions among these dimensions, which makes the process problematic. Indeed, these dimensions are not in casual or predictive relation with each other, but interacting. Those interactions revealed some professional profiles, which are exhaustive as mentioned before.

According to the findings of the study, there are two main patterns of professional profiles. The patterned professional profiles reveal a common aim (such as legitimation or delegitimation of TCM), emphasis on some legitimacy criteria and on some practices. Therefore, the dominant professional profiles, which lead the legitimation process of TCM in THCS, are: (1) Socialist – Not market oriented – Materialist (2) Moderate – Market oriented- Holistic. There are some exceptional patterns of professional profiles as well. Profiles are analytic and predictive of legitimacy criteria selections. The list of the

participants according to their corresponding profile is in the table of Appendix F. Moreover, the table in the Appendix G figures out which participant deploys which legitimacy criteria for which TCM practice.

The first dominant professional profile (Profile 1) involves professionals who approach to the healthcare from holistic view and market oriented. However, these professionals are not driven by any ideological standpoint thus possess a moderate view. The main aim of those professionals is to legitimate TCM practices in THCS. In order to reach this aim, those professionals deploy some legitimacy criteria for some TCM practices systematically. These professionals emphasize relatively less contested TCM practices in their rhetoric, mainly acupuncture. They strongly use the regulative legitimacy in terms of state recognition and WHO approval. Besides, they exemplify effective results of some TCM practices. The common tendency of those professionals is to hesitate to use moral legitimacy criteria of application of the prophet or nationality. Instead, they emphasize the philosophical aspects TCM practices that is self healing power of the body.

Table 17 summarizes of participant professionals of the sample in the profile 1 according to their distribution over the regulated TCM practices and the legitimacy criteria they use in evaluating that practice[31]. Depending on this distribution, it can be said that, majority of the profile 1 professionals evaluate the TCM practices individually and as a bundle in a positive manner, thus legitimize them. Besides, majority of them refer to the bundle as a whole or least contested practice such as acupuncture. Main legitimacy criteria they use are being harmless and effective, state's regulative recognition and pragmatic dimensions such as being cheap for the budget.

[31] In this table number of the sings show that how many participants fall in that cell. The meaning of the sign + implies that, those participants evaluate that practice with that criteria in a positive manner, thus legitimize it.

Table 17 Distribution of the participants in Profile 1 according to the legitimacy criteria they use for different TCM practices

Corresponding Legitimacy Dimension	Legitimacy Criteria	TCM Bundle as a whole	Acupuncture	Cupping Therapy	Hirudotherapy	Phytotherapy	Hypnosis	Homeopathy	Music Therapy
Normative	Effectiveness of the results (of the treatment)	++++++	++++	+					
Normative	Harmless (treatment)	++++++	+++++	++++	++	++			
Normative	Safety								
Normative	Validity	+							
Normative	Doctors' choice of treatment	+							
Regulative	State's regulatory recognition	++++++++++++++++++++	++	++++	+		x		
Regulative	WHO acceptance	+++	+	+					
Moral	National	++	++						
Moral	Application of the Prophet			++		++			
Moral	Philosophy of the treatment	+	++++				x		
Pragmatic	Economic value	+++	+			+			

Pragmatic	Expensive / Cheap for State Budget	+++++	+++			+			
Corresponding Legitimacy Dimension	**Legitimacy Criteria**	**Prolotherapy**	**Mesotherapy**	**Ozone Therapy**	**Osteopathy**	**Chiropractic**	**Apitherapy**	**Reflexology**	**Maggot Therapy**
Normative	Effectiveness of the results (of the treatment)		+		++	+	+		
Normative	Harmless (treatment)			++	+				
Normative	Safety								
Normative	Validity								
Normative	Doctors' choice of treatment								
Regulative	State's regulatory recognition	+	+++	++	++	+			
Regulative	WHO acceptance								
Moral	National								
Moral	Application of the Prophet								
Moral	Philosophy of the treatment		x		+				
Pragmatic	Economic value			+					
Pragmatic	Expensive / Cheap for State Budget			+					

Second dominant professional profile (Profile 2) involves professionals who approach to the health care from materialist perspective, share the idea of socialist health provision and they are not market oriented. The main aim of those professional during the legitimation process is to delegitimate the legitimated entity. In order to reach this aim, those professionals deploy some legitimacy criteria for some TCM practices systematically. For example, professionals in this profile (such as ID # 5, 13, 16, 17, 27 and 52) emphasize the harmful case examples, ineffective results, invalid research methodologies to delegitimize traditional practices such as cupping therapy, hirudotherapy and music therapy. They emphasize the outcast position and the religious aspects of those practices in delegitimation. For complementary ones, pragmatic aspects such as expensiveness for the patients emphasized to delegitimate practices such as mesotherapy or phytotherapy. Therefore, the rhetoric they developed reflect the interaction between TCM practice they try to delegitimize and the legitimacy criteria they choose.

Table 18 summarizes participant professionals of the sample in the profile 2 according to their distribution over the regulated TCM practices and the legitimacy criteria they use in evaluating that practice[32.] As the table figures out that majority of the participants in this profile use various legitimacy criteria in a negative manner in evaluating individual TCM practices or the TCM bundle as a whole. Participants in the profile 2 do not talk about the complementary TCM practices such as Prolotherapy or Ozone Therapy. Instead they evaluate the bundle as a whole or focus on traditional practices such as cupping therapy.

[32] In this table number of the sings show that how many participants fall in that cell. The meaning of the sign + implies that, those participants evaluate that practice with that criteria in a positive manner, thus legitimize it. Whereas, meaning of the sign x implies that, those participants evaluate that practice with that criteria in a negative manner, thus delegitimize it.

Table 18 Distribution of the participants in Profile 2 according to the legitimacy criteria they use for different TCM practices

Corresponding Legitimacy Dimension	Legitimacy Criteria	TCM Bundle as a whole	Acupuncture	Cupping Therapy	Hirudotherapy	Phytotherapy	Hypnosis	Homeopathy	Music Therapy
Normative	Effectiveness of the results (of the treatment)	xx	x	x	x				
Normative	Harmless (treatment)	xxxx +		x	x				
Normative	Safety								
Normative	Validity	xxx							
Normative	Doctors' choice of treatment								
Regulative	State's regulatory recognition	xxxx							xx
Regulative	WHO acceptance								
Moral	National	++							x
Moral	Application of the Prophet								
Moral	Philosophy of the treatment	xx							
Pragmatic	Economic value	x				x		x	
Pragmatic	Expensive / Cheap for State Budget	x				x		x	
Corresponding Legitimacy Dimension	**Legitimacy Criteria**	**Prolotherapy**	**Mesotherapy**	**Ozone Therapy**	**Osteopathy**	**Chiropractic**	**Apitherapy**	**Reflexology**	**Maggot Therapy**
Normative	Effectiveness of the results (of the treatment)								
Normative	Harmless (treatment)		x			x			
Normative	Safety								

Normative	Validity								
Normative	Doctors’ choice of treatment								
Regulative	State's regulatory recognition								
Regulative	WHO acceptance								
Moral	National								
Moral	Application of the Prophet								
Moral	Philosophy of the treatment								
Pragmatic	Economic value								
Pragmatic	Expensive / Cheap for State Budget								

Apart from these dominant professional profile patterns, there are some exceptions as well (Exceptional profiles). As the Table 19 below summarizes, exceptional profiles do not show any patterned way of evaluation in terms of their positive or negative approach to the individual TCM practices or the TCM bundle as a whole. Instead, there are dispersed evaluations either legitimize or delegitimize different practices on different grounds (See explanation of the sings in Table 19 in the footnote 32).

Table 19 Distribution of the participants in Exceptional Profiles according to the legitimacy criteria they use for different TCM practices

Corresponding Legitimacy Dimension	Legitimacy Criteria	TCM Bundle as a whole	Acupuncture	Cupping Therapy	Hirudotherapy	Phytotherapy	Hypnosis	Homeopathy	Music Therapy
Normative	Effectiveness of the results (of the treatment)	x ++++	+++	++ x	x +	++	+	+	x
Normative	Harmless (treatment)	++++	++++	++					
Normative	Safety	+							
Normative	Validity	+							
Normative	Doctors' choice of treatment	+							
Regulative	State's regulatory recognition	++++++++	+		+ x	++	+	+ x	+
Regulative	WHO acceptance	++	++						
Moral	National	+	+						+
Moral	Application of the Prophet			++					
Moral	Philosophy of the treatment	+	+		x			+ x	
Pragmatic	Economic value	+							
Pragmatic	Expensive / Cheap for State Budget	++				+		+	
Corresponding Legitimacy Dimension	**Legitimacy Criteria**	**Prolotherapy**	**Mesotherapy**	**Ozone Therapy**	**Osteopathy**	**Chiropractic**	**Apitherapy**	**Reflexology**	**Maggot Therapy**
Normative	Effectiveness of the results (of the treatment)		x						

Normative	Harmless (treatment)	x	x						
Normative	Safety								
Normative	Validity								
Normative	Doctors' choice of treatment								
Regulative	State's regulatory recognition		+ x	+					
Regulative	WHO acceptance								
Moral	National								
Moral	Application of the Prophet								
Moral	Philosophy of the treatment								
Pragmatic	Economic value	x	x						
Pragmatic	Expensive / Cheap for State Budget								

For example, one of the professionals from the first professional profile (participant ID # 17) declared that:

> If they have got value among the public, we cannot deny them [TCM practices] totally. That is the point at which I stand differently from other opponent colleagues. […] There is an acceptance that, if public benefit exists, if TCM increases life standards and does not harm anyone, it can be practiced. I am at that position now (Participant ID # 17).

As the above excerpt indicates the participant declares his tolerance to some TCM practices (the ones accepted by public) under some circumstances (not harmful, increase of life standards). Indeed, there is not any aim of legitimation or delegitimation in this excerpt but departs from the other professionals of the same profile.

Another example for the exceptional professional profile is consist of 11 professionals in the sample who declared that they oppose to any one of the TCM practice, albeit have certificate or they are practitioner of another TCM practice. Table 20 summarizes these professionals.

Table 20 Summary of TCM Practitioner Participants Who Are Opposed to a Practice

Interviewee ID	Occupation	TCM Practitioner?	Which Practices Practiced?	Opponent of Any Practices?	Opposed to Which Practices?
14	Pharmacist	Yes	Phytotherapy	Yes	Hirudotherapy
25	Medical doctor	Yes	Acupuncture	Yes	Not declared
33	Medical doctor	Yes	Acupuncture Ozone Therapy Cupping Therapy Mesotherapy Hypnosis Manual Therapies	Yes	Not declared (to the ones with market concerns)
35	Medical doctor	Yes	Acupuncture	Yes	Cupping Therapy (no need, acupuncture can suffice) Ozone Therapy Mesotherapy Prolotherapy (practiced with economic concerns; injection of medicine, not TCM)

37	Medical doctor	Yes	Acupuncture Cupping Therapy Hirudotherapy Phytotherapy	Yes	Homeopathy (on religious grounds)
42	Medical doctor	Yes	Cupping Therapy Hirudotherapy Phytotherapy	Yes	Hypnosis Homeopathy (on religious grounds)
43	Medical doctor	Yes	Cupping Therapy Ozone Therapy Hypnosis	Yes	Hirudotherapy (even has certificate)
46	Dentist	Yes	Cupping Therapy Ozone Therapy Phytotherapy	Yes	Hirudotherapy (insome cases finds it funny to apply)
48	Medical doctor	Yes	Acupuncture	Yes	Not declared
50	Medical doctor	Yes	Acupuncture	Yes	Wet Cupping Hirudotherapy Mesotherapy
51	Medical doctor	Yes	Osteopathy Acupuncture Cupping Therapy Hypnosis Hirudotherapy Homeopathy Phytotherapy Reflexology	Yes	Mesotherapy

Some of the professionals in this profile did not declare which practices they oppose (such as Participant ID # 25) or the reason for their opposition (such as Participant ID # 48), whereas some of them declared their opposition in general terms such as “I find it funny” (for hacamat or hirudotherapy, Participants ID # 46, 50).

Some of the practitioner participants clearly define the misfit between their mindset and the attributes of some TCM practices:

> There are some practices that make me laugh, like cupping therapy or hirudotherapy. I personally do not apply them to any patient and will not allow them to be applied to me. I learned about them and they are not commensurable with my logic. (Participant ID # 50).

Participant ID # 37 declared that she does not approve of the regulation of ‘homeopathy’ for religious grounds.

> I don’t find [homeopathy] appropriate since we don’t know what is loaded in that remedy. Remedies are imported, who prepares them, how? Do they include some praying? (Participant ID # 37).

Therefore, professional profiles interact with legitimacy criteria choices and practice to be evaluated from the TCM bundle. That is why, apart from two main professional profiles who are trying to legitimate or delegitimate the TCM practices in THCS, exceptional profiles do not reveal any patterned way of rhetorics or actions.

7. DISCUSSION

In this chapter, I will discuss the theoretical contributions and some practical contributions of this research. First, I will discuss legitimation as a multidimensional process including interactions among the dimensions of the legitimation process. Second, I will discuss the main findings of the process, namely emergent professional profiles. I will end the chapter by discussing some unexpected outcomes of the study.

The extant literature about legitimacy has considered legitimation as a unidimensional process, as mentioned before. That is, most of the studies focus on only one aspect of the process: the legitimated entities, the legitimators, or the legitimacy criteria. Moreover, most of these studies overlook the multiplicity of those aspects and potential interactions among them.

In the present framework, I have conceptualized legitimation as a multidimensional process that includes legitimated entities, legitimacy criteria, and legitimators together with the interactions among them. I have assumed that the legitimation process may include dimensions of bundles of practices that were outcast, and that there is a multiplicity of legitimacy criteria and professional contestation regarding these bundles of practices and legitimacy criteria. The evolving interaction among these dimensions may make the legitimation process problematic in nature. The empirical findings, which were explained in the previous chapter, revealed some explanations for my initial conceptualization of legitimation as a multidimensional process.

Apart from conceptualizing legitimation as a multidimensional process, I have assumed some points that ensure the avoidance of potential bias and avoidance of omission of some critical dynamics. Multidimensionality may also provide avoidance of ignoring the continuous problematic nature of legitimation in a multidimensional space. To avoid potential biases any study should avoid focusing on a single practice, legitimacy criterion, or should avoid to accept any legitimator group as similar. Besides, the critical dynamics of the process, such as interactions among these dimensions, must be considered to capture the overall complexity of legitimation. Finally, legitimation is an evolving process, which cannot be simply summarized in the form of reaching the consequences of an evaluation once and all.

Professionals have initiated a legitimacy contestation of TCM integration into the THCS. Laypeople in society had been practicing some TCM practices, especially the traditional ones, for some time. The TCM bylaw of 2014 authorized only medical doctors and some medical assistance staff to apply TCM, thus providing regulative legitimacy to TCM practices. However, individual medical professionals, on different grounds, as explained in the previous chapters, do not necessarily approve of each practice. There are diverse legitimacy evaluations of professionals with multiple criteria. The legitimated practices also constitute a heterogeneous bundle. Thus, the empirical situation of TCM integration into the THCS is suitable for theorizing legitimation as a multidimensional process that involves legitimated practices, legitimacy criteria, and professionals. The legitimation of TCM into the THCS has provided room to avoid unidimensionality biases. Moreover, the empirical context has provided insights into the potential interactions between these dimensions, highlighting a complex and contested process of legitimation.

TCM practices constituted the first dimension of the legitimation process of TCM into the THCS. Those practices are not new practices or innovations to be legitimated as is usually seen in the extant literature (Laïfi & Josserand, 2016; Lounsbury & Crumley, 2007; Markowitz et al., 2012; Navis & Glynn, 2010). Instead, some of the regulated TCM practices have extensive historical background; some practices were recorded in historical medical texts and some experienced a contested historical process over the period of 100 years during which modern medicine became dominant in healthcare systems including the THCS. For example, the usage of leeches in hirudotherapy and cupping therapy (hacamat) were denigrated within formal medical education after the establishment of the Turkish Republic, as explained before. Therefore, the legitimation of cupping therapy in the THCS is not a process of a new medical treatment launching in the organizational field. The practice, which can be assumed as outcast, brings the memory attached to it during the legitimation process, which makes it unlike legitimation of a new practice or innovation. Empirically, not every participant in the sample of this study agreed with the outcast position of some TCM practices. On the other hand, some participants emphasized the outcast position of some TCM practices with expressions like “I find it funny” (for hacamat or hirudotherapy, Participants ID # 46 and 50 respectively).

In addition, TCM practices constitute a heterogeneous bundle, which represents a departure from the existing literature of legitimation. According to the present findings, TCM practices

differ from each other in terms of at least five main dimensions, which are being TM/CM, requirement for drugs, possession of any core philosophy, having a historical background, or being mentioned in religious texts. The heterogeneity of TCM practices reveals an interaction with the legitimacy criteria chosen to evaluate that practice by any participant professional.

For example, for one participant (Participant ID # 50), acupuncture and music therapy are legitimate healing methods whereas mesotherapy is debatable. According to him, the legitimacy criteria for each legitimacy evaluation differ as well: WHO acceptance and a domestic history are criteria for acupuncture and music therapy, respectively, while perceived inefficiency and being harmful are negative factors for mesotherapy.

For another participant (Participant ID # 13), acupuncture is not effective but it is approved by the WHO and thus can be tolerated. On the other hand, for the same participant, WHO approval of some other TCM practices (such as cupping therapy) is not acceptable since their contextual philosophies are ideologically debated.

Therefore, the participants of the sample constitute a kind of bundled legitimation of TCM practices, which is reflected in the usage of multiple legitimacy criteria. There seems to be an obvious interaction among practices to be legitimated and legitimacy criteria used by professionals.

The second dimension of the legitimation process is legitimacy criteria. Previous studies that focused solely on legitimacy criteria relied on the institutional pillars defined by Scott (1995), as mentioned before. Therefore, the extant literature focuses on regulative legitimacy (Dobrev, 2001; Kwiek, 2012) or normative legitimacy (Deephouse & Suchman, 2008; Ruef & Scott, 1998). Some studies take into consideration cognitive legitimacy, either from an institutionalist perspective (Vaara, 2014; Vaara & Monin, 2010; Vaara & Tienari, 2008) or from an ecological perspective (Rossman, 2014). Apart from these general types of legitimacy criteria, there are some specific types of criteria as well, such as the environmental legitimacy of Bansal and Clelland (2004). Some previous studies did approach legitimation from a multidimensional perspective (Fisher et al., 2017; Laïfi & Josserand, 2016). However, they did not explain the critical dynamics of interactions between various dimensions. Indeed, the literature regarding micro-processes of legitimacy evaluations offers ideas about how and why different actors may appeal to different criteria (Bitektine, 2011; Bitektine &

Haack, 2015). There are also studies on hybridization and decoupling that provide theorizations of heterogeneity in legitimacy evaluations. However, they do not provide conceptualization at the macro level.

The findings of this study revealed that professionals might appeal to some specific legitimacy criteria during a legitimation process of TCM practices into the THCS. However, those legitimacy criteria reflect participants' approaches to healthcare provision and the legitimacy of any medical treatment (whether TCM or not). This means that professional participants in the sample have some standards (legitimacy criteria) for evaluating medical treatments and thus deploy them in evaluating TCM practices as well. Those specific legitimacy criteria are being harmless, being effective, safety, validity, doctor's choice, state recognition, WHO acceptance, being of national origin, application by the Prophet, the philosophy of the treatment, economic value, and being expensive or cheap for the state budget. Moreover, they correspond to some predefined legitimacy dimensions as normative legitimacy, regulative legitimacy, moral legitimacy, and pragmatic legitimacy. Therefore, professionals use multiple legitimacy criteria in this study, which is in accordance with the extant literature. However, the importance of this work does not emerge from the multiplicity of legitimacy criteria. The most important point here is the existence of legitimacy criteria interactions with practices and professionals.

For some participants, it is important whether any medical treatment (including TCM practices) requires injections or the taking of any medical drugs. Some participants linked that attribute to the philosophical characteristics of the treatments (if any). For example, Participant ID # 35 legitimized acupuncture with its attribute of not requiring drugs by evaluating the practice with the legitimacy criterion of the philosophy of the practice (self-healing according to the ying yang theory). Similarly, for another participant, the same attribute may result in being harmful. Participant ID # 50 delegitimized mesotherapy with its drug injection attribute, deploying the criterion of being harmless. For some participants, procedures involving drugs may lead to a burden on the state budget. For example, Participant ID # 16 delegitimized phytotherapy, deploying the criterion of being expensive.

The third dimension of the multidimensional legitimation process is professionals. At the beginning of this study, I argued that the extant literature on legitimacy contestations (which involve multiple legitimacy criteria) reveals professional contestations as well. Contestations among professionals of these kinds are explained by the status of the professionals in a field,

which is accepted as a determinant of choices of professionals (Currie & Spyridonidis, 2016b; Suddaby & Viale, 2011; Wry, Lounsbury, & Glynn, 2011). For example, Currie et al. (2012) proposed that dispersed professionals may form groups such professional elites depending on being at the center or the periphery. There may also be a hierarchy among some professionals in the same field, such as that observed between nurses and medical doctors (Currie & Spyridonidis, 2016b).

However, the results of my research did not reveal such variance among participating professionals in terms of their academic career (e.g., being a professor or without a title), specialty (being an anesthetist or being in physical treatment or dermatology does not constitute any difference), or medical profession (being a medical doctor or a pharmacist does not constitute any difference).

Furthermore, in the case of a legitimacy contestation, professionals are classified as proponents and opponents in the extant literature (Joutsenvirta & Vaara, 2015; Suddaby & Greenwood, 2005; Vaara, 2014; Vaara & Tienari, 2008). The 'proponent' and 'opponent' classification of professionals reveals their strategic legitimation or delegitimation actions (Vaara, 2014; Vaara & Tienari, 2008; Vaara et al., 2006), which constitute the patterns of the rhetoric they appeal to or some entrepreneurial actions such as resource allocation (Fisher et al., 2016), thus clarifying their legitimacy criteria.

When considering the historical and political processes of the THCS field, it is expected that Turkish professionals may fall into contestation over any regulation. However, in TCM integration, professionals' debate over the entities of healing, which is conditioned by their medical education, is expected to be standard. Therefore, professional division in the THCS is independent of TCM legitimation but exists as explained in the findings section.

Attribute coding of the participating professionals allowed two things in this study. First, the coding provided explanations for how professionals combine different legitimacy criteria and legitimated practices together, albeit not in a linear and causal form. Second, it enabled classification of the professionals into some profiles.

According to the findings, the professional schism in the THCS reveals three main analytic categories of professionals that are independent of the TCM integration process. Those are being holistic or materialist; being market-oriented or not; and positioning oneself in any

ideological or political position including being socialist, nationalist, religionist, or moderate and ignoring such differences.

The first category of being holistic or materialist depends on the professionals' approach to healing patients. A holistic approach to healing people means that medical professionals avoid thinking in a particularistic way. In other words, the medical doctor evaluates the human body as a whole with its physical and non-physical parts (such as mind, spirit, etc.). One of the participants defined being holistic as an artistic talent in discovering the relation between tinnitus and a drooping finger of a patient (Participant ID # 44). This approach to the healthcare system contrasts with the official medical education in Turkey since the system includes many specialties (İzgi & Çoban, 2014). The organizational form of hospitals is also structured according to the basis of specialties. Therefore, application of holism has some obstacles in practice. However, some professionals clearly defined themselves as holistic in this manner.

On the other hand, some professionals defined themselves as being holistic because they appeal to TCM and modern medical practices in a bundle. This approach differs from the former one, since there is an inference of putting any one of them into a complementary position as professionals have to make a choice in healing people. This is the point where the objection towards holistic professionals emerges from the materialist view. Although the category of being a materialist was extracted from the holistic professionals' definitions of their opposing colleagues, few of the participating professionals defined themselves as being materialist. Those professionals criticized the latter group of holistic colleagues, stating that modern medicine is well developed to fulfill the healthcare needs of the public. Therefore, the first category reveals the paradigmatic approaches to healthcare provision.

The second category of division among professionals in the THCS is related to being market-oriented or not. Marketization of healthcare includes the for-profit organizational form of healthcare provision and the existence of commercial forces driving healthcare provision, as mentioned before. Turkey has been experiencing marketization of healthcare since the 1980s (Soyer, 2001) and thus there has been a division among professionals regarding this category for years. Some professionals welcomed the gain of money from healthcare provision (including the provision of any TCM practices, as well), whereas some of them expressed their ignorance on this topic. On the other hand, some non-market-oriented professionals

strictly opposed the marketization of healthcare provision since they saw healthcare access as a human right.

The third category reflecting professional divisions in the THCS involves the political or ideological standpoints of the professionals. There are four main dimensions of this category, which are being socialist, nationalist, religionist, or moderate. The majority of the participants defined their ideological standpoints during the interviews, whereas some of them hesitated to talk about these subjects. Some participants also expressed their ignorance of ideological and political issues when talking about healthcare provision. That is why there is the category of 'moderate'. On the other hand, some professionals clearly defined their political approach and ideology by using some keywords as explained in the findings section.

Professionals constitute one of the dimensions of the legitimation process. Thus, the professional schism of Turkish professionals in the THCS, though not directly related to the legitimation process, is in interaction with the practices to be legitimated and legitimacy criteria choices. However, such an interaction is not predictive as studied in other multidimensional legitimacy process studies (Fisher et al., 2017; Laïfi & Josserand, 2016). Legitimation is interactively evolving with the constellation of professionals, practices, and legitimacy criteria.

In other words, the professional contestation that started after the 2014 TCM bylaw about the legitimacy of TCM practices in the THCS is not only related to the existence of multiple legitimacy criteria. It is not only related to either the outcast nature of TCM practices or to the fact that they constitute a heterogeneous bundle. It is not only related to the existing professional schism in terms of professionals' approaches to the healthcare provision or their ideological or political views. The legitimation process itself is contested and problematic. Thus, legitimation can be studied in an unbiased way without ignoring critical dynamics and with the capturing of the overall complexity only if it is regarded as multidimensional.

Empirically, the interactions among professionals, TCM practices, and legitimacy criteria extracted from the data explain how legitimation unfolds in this complex and contested context. As mentioned before, there are two main dominant patterns shaping the process of TCM legitimation in the THCS. These are two main opposing forces, one of which works to legitimize whereas the other one works to delegitimize the TCM practices. The first main dominant pattern (that is socialist – not market-oriented and materialist) delegitimizes TCM

practices, emphasizing the outcast ones, by using criteria of ineffectiveness or harmfulness. Those professionals delegitimize TCM practices that are not in an outcast position by describing their economic value as a burden on the state (or on patients) on pragmatic grounds. On the other hand, holistic – market-oriented and moderate professionals constitute the other dominant professional pattern. They are working on the legitimation of TCM practices, focusing on the least contested ones such as acupuncture in their rhetoric and promotion while avoiding the promotion of outcast ones. They disregard ideological and political schisms in the field. They have an emphasis on deploying regulative and moral legitimacy criteria by specifically focusing on philosophical aspects of some TCM practices (such as the yin-yang theory and self-healing philosophy of acupuncture) or focusing on WHO and state recognition of TCM.

Although these are two main dominant patterns of professional profiles, there are some exceptional profiles, as well. For example, one exceptional profile emerged as 'socialist and not market-oriented'. This profile supports socialist healthcare provision and rejects marketization of healthcare provision. However, it is in between holism and materialism in terms of the approach to healthcare provision, since professionals with this profile tolerate some TCM practices in the case of being harmless and providing motivation for patients (such as Participants ID # 17 and 52).

In another profile, one of the participants defined herself as holistic and religionist (Participant ID # 37). However, she is not market-oriented; she works in a public hospital and criticized the emergence of the new market of TCM. Ideologically, she expressed her preference for moral legitimacy criteria, specifically applications of the Prophet. On the other hand, she insisted on the necessity of documentation of clinical observations to prove the effectiveness of the results of TCM practices to opposing colleagues.

These professional profiles, both the dominant and the exceptional ones, emerge from within the Turkish context. In other contexts, studying the multidimensionality of legitimation with the interactions among practices, criteria, and professionals, these profiles may not be revealed. Maybe there may also be other emergent profiles. To capture the exact interactions in any legitimation process, it is necessary to measure multiple dimensions from the very beginning. For example, in the sample of this study, there is not any socialist-holistic or socialist and market-oriented participant. However, there may be in other contexts. Similarly, there are participants who are religionist or nationalist and materialist with market

orientation in the Turkish context. Those professionals are very exceptional and do not provide any rhetorical pattern but analytically possible as well.

TCM integration into the THCS is an evolving process. In the future, they may be scenarios of unbundling legitimated practices and providing independent legitimation processes for each of them. Some TCM practices may be excluded from the system or new TCM practices may be legitimated. It is possible that some emergent legitimacy criteria may lose their relevance, as well. Furthermore, some professional profiles that are exceptional today may become dominant in the future, or dominant ones may lose their dominance. Legitimation is constantly contested because of the three main dimensions and interactions among them. For a legitimation process (including TCM integration into the THCS), it is not possible to reach a simple conclusion of evaluation as 'legitimate' or 'illegitimate'. It is necessary to observe all the process with the interactions among several dimensions. Legitimacy evaluation is a multidimensional process, which unfolds with the questions of: Legitimacy for whom, and legitimation of what? In addition, legitimation on which grounds? These questions should be asked continuously in examining any legitimation process to capture the overall complexity and to avoid potential biases.

Deephouse et al. (2017) examined legitimacy from a multidimensional perspective, asking similar questions of what legitimacy is, why it matters, who confers it with what criteria, and how it changes over time. However, neither they nor any other scholars examined the legitimation of any entity with a model combining multiple dimensions. This is what has been done in the present study and what constitutes the main contribution of the study. Those questions should be considered in any legitimation process.

Apart from these main theoretical contributions to the legitimacy and the professional literature, there are some other points that emerged from the present findings. These can be accepted as unexpected outcomes of the study, or signs of other dimensions to be considered in a legitimation process.

First, the emergence of some specific legitimacy criteria (such as applications of the Prophet as a legitimacy criterion in the healthcare field) constituted a nascent finding of this research: the legitimacy of legitimacy criteria. Some participants questioned the evaluation of TCM practices according to deviant standards of medical healing. For example, for some professionals, market value cannot constitute a legitimacy criterion of any TCM practice

because of ethical issues, such as Participant ID # 17. This participant supports the idea that marketization should not be an issue in healing people. Similarly, a majority of the participants criticized appealing to the applications of the Prophet in legitimizing cupping therapy since religion is not an acceptable legitimacy criterion for evaluation of any medical treatment, including TCM practices.

Second, the extant legitimacy literature defines the nation state as a rational actor that provides regulative legitimacy (Scott et al., 2000) and in some instances moral legitimacy (Laïfi & Josserand, 2016) to the entities of legitimacy. However, the findings of this study revealed query regarding the rationality and objectivity of the state as a legitimator. Some participants accept the regulative legitimacy of the state as the primary reason for their approval of TCM practices (such as Participant ID # 36). However, some others blame the regulative authorities of the nation state for 'not acting objectively' to provide freedom to each voice in regulation (such as Participants ID # 13, 16, 17, and 19). In addition, some participants declare the 'irrationality of integrating TCM' in a field in which the dominant paradigm of modern medicine is sufficient in healing people (Participant ID # 27). Thus, they question the legitimacy of the regulation as a whole. Political processes that countries experience may contextualize any legitimation process (Holm, 1995). In the Turkish context, the findings revealed that political struggles between different stakeholders that are unrelated to the healthcare field influence the TCM integration process. For example, some participants (such as Participants ID # 13, 16, and 17) argued about current government policies regarding national education or environmental issues being inappropriate, revealing a link to the government's general attitude towards managing the country. Feelings about global regulative authorities like the WHO (a debated organization for some participants, such as Participants ID # 49 and 52) can also determine the evaluation of TCM integration into the THCS.

Third, in addition to the state, another conventional legitimacy source, professional associations, is debated in the Turkish context, as well. Professional associations have the role of defining and refining the appropriate form of actions for their members (Greenwood et al., 2002), thus determining jurisdictional boundaries. In some studies, membership in a professional association is defined as a criterion of legitimacy, as well (Wry et al., 2011). Traditionally, professional associations are regarded as providers of normative consonance (Scott et al., 2000) and moral endorsement (Laïfi & Josserand, 2016).

On the other hand, in this study, a majority of the participants questioned the legitimacy of a professional association, the TMA. The evaluations of the TMA were defined as 'ideological' and 'political' by some participants (such as Participants ID # 1, 43, 45, and 50), not only regarding TCM integration but also the THCS in general. Some participants declared that their membership is simply a requirement of law and claimed that the TMA is not representing them (such as Participant ID # 42). Thus, the normative power of the professional association in Turkey is not construed similar to other national contexts according to the results of this study.

Fourth, participating professionals in the present study appeal to their future expectations, which reflects their existing legitimacy evaluations, as well. This is something that is not discussed in the legitimacy literature.

For example, some participants stated that the efficiency of some TCM practices may be proved by scientific evidence in the future (such as Participants ID # 39, 40, and 44). Therefore, they expect to capture scientific legitimacy in the future even though it is not a criterion that they currently use for those practices. For example, Participant ID # 39 expressed her observations of patients and used the subjective wellbeing category of effectiveness legitimacy criteria. She admits that those results cannot be measured by existing technology. Nevertheless, she expects to use scientific legitimacy in the near future, when measurability will be achieved.

Some participants also revealed the possibility of the elimination of some regulated TCM practices in the future (such as Participants ID #4 and 51, without indicating practice names), whereas some participants predicted the inclusion of some other TCM practices in the near future (such as Participants ID # 18 and 28 for bioenergy[33]).

Therefore, professional concerns about the future seem to be driving current legitimacy evaluations in the THCS.

Fifth, according to the findings of my research, TCM integration has included a debate over the question of who is qualified to perform TCM practices, which is in accordance with the existing literature. The state, with the TCM bylaw of 2014, regulated the accreditation

33 Bioenergetics is the study of the transfer of energy and the way one living system relates to others (Navarra, 2004).

standards, providing provisions for certificate programs and standards of education programs as well. However, interview results revealed that some TCM practices require specific qualifications of the practitioners (such as osteopathy, chiropractic, and homeopathy according to Participants ID # 44 and 51). Therefore, there is a trait-based approach to professionalism (Suddaby & Muzio, 2015) in terms of TCM practices according to the findings of this research. This trait-based approach supports the idea that there are some key traits that distinguish the professions from other occupations (Muzio et al., 2013).

Indeed, findings about the return to a trait-based approach to professionalism can be accepted as an unexpected outcome of this research since, according to recent studies, trait-based approaches were a thing of the past (Muzio et al., 2013; Noordegraaf, 2011).

Finally, there might be a contribution to the TCM literature, as well. Regarding TCM integration, studies are divided in explaining whether the marketable value of TCM practices led to the integration processes of countries (Mizrachi et al., 2005) or if any other social movements, such as 'turning to nature', were responsible (O'Callaghan & Jordan, 2003). Results of this study reveal that professionals of the THCS agree with the former of these arguments as there is no implication of any kind of social movement in the Turkish context.

I have discussed some theoretical insights of this dissertation in this chapter. I will end with the conclusion in the next chapter.

8. CONCLUSIONS

Empirically I have explored legitimation as a multidimensional process. Legitimated practices, legitimacy criteria and professionals as legitimator actors proposed to be involved. The findings revealed that, not only the complexity of the dimensions but also interactions among them lead legitimation be contested and evolving in the space. The empirical context that gave rise to explore such theorizations is TCM integration into the THCS.

I conducted qualitative research over the course of three years, which provided the data and conceptual insights for studying contested legitimacy and professional divisions.

Theoretically, I extended the legitimacy literature via detailed conceptualization of a legitimation as a multidimensional process. Specifically, I contributed to the literature on professionals by extending the professional division in case of contested legitimacy. Besides I contributed to the TCM literature by providing a contextual form of legitimation of TCM driven by various dimensions.

As a result of this research, there are some managerial and practical implications for medical professionals and regulative authorities. I will also explain some limitations that lessen the explanatory power of the study in the next subsections. At the end, I will finish this dissertation with suggestions for future studies, which may address the deficiencies of the current study.

8.1. Managerial and Practical Implications

Although a radical shift did not occur in the THCS after the 2014 TCM bylaw, there seems to be a diffusion of application centers, education centers, and units in Turkey. The debate over the regulation in terms of its manner, its content, and its necessity has been increasing without doubt. The process is four years old as of November 2018 and does not reveal any consequences, although it is explored in terms of its evolving nature. However, as the findings indicate, it has provided insights about the healthcare field and professionals, as well.

First, the content of the bylaw text does not include any description of which practices are traditional and which are complementary. This brings about the fatal problem undermining the process. As explained before, there is a wide difference among the practices that are

traditionally and culturally embedded in local contexts and the complementary ones. The findings of this research revealed that professionals appeal to these two groups differently and evaluate their acceptability on different grounds. Therefore, putting diverse practices into the same bundle seems to be the main reason for legitimacy contestation of the TCM integration process in the Turkish context, which is possible to eliminate legally.

Second, the tension between professional associations and regulative authorities reflected in the interview excerpts of this research and in other data sources constituted another barrier of field-wide acceptance of TCM practices. Majority of the participants attribute value to the provision of a field-wide consensus. However, disputes over out-of-field concerns seem to undermine the consensus process. One of participants declared that "The valuable part is that we are talking about TCM now, we were not talking about it in the past" (Participant ID # 51). This pinpoints the importance of communication in an organizational field. Any professional profile must communicate about the issue without prejudgment according to this participant.

For example, the Turkish Ministry of Health excluded the term 'alternative' from the bylaw text, which existed in the draft title, before officially launching the bylaw. The term was removed from the related department of the Ministry of Health, as well. The term draws resistance not only in the Turkish context but in other parts of the world as well. Although 'alternative' is not included now, the TMA uses the term in its reports, linking the controversial term to others (Türk Tabipleri Birliği Halk Sağlığı Kolu, 2017).

There are some reconciliation steps, as well, such as establishment of Traditional and Complementary Medicine Commissions by some local associations. Indeed, when the THCS is considered as a whole, there is a group of medical professionals who can be defined as 'ignorant', who have no information and thus no idea about TCM practices. Some of them had not heard about the 2014 bylaw, either. Therefore, TCM integration is a concern of the limited number of professionals who are interested in the field or resistant to the field. Field-wide diffusion probably requires efforts involving more communication, more publications, and more time.

Finally, there are some limited implications for the emergence new organizational forms according to the results of this study. That is a hospital setting including integrative medicine (see Appendix A for description), which includes provision of modern medicine and TCM

practices in collaboration. Although it seems that such an emergence would occur in the long run, if it is the target, the managerial and structural infrastructures should be prepared.

8.2. Limitations of the Study

There are some limitations of this study, which created obstacles in offering a better conceptual and contextual realm.

First, the unclear nature of the concepts in the TCM field and related literature created difficulty in conceptualizations for me. In determining which words to use to represent mainstream healthcare systems, it was necessary to search dispersed databases of the medical sociology literature. Apart from being time-consuming, this situation created obstacles in reaching systematized data, as well. For example, I used the term "modern medicine" to cover contemporary mainstream medicine. However, searching with this term excludes possible sources and data that possess terms like "orthodox medicine" or "western medicine".

Secondly, there were no quantitative or qualitative data providing information or indicating a pattern in Turkey. Although there are some local studies, they focus on patients' choices and on individual TCM practices. There is no nationwide study covering professional approaches to TCM practices. While this provides an opportunity to bridge a gap in the research, there is no benchmark to compare results for conformity.

Another limitation of the study is related to some marginal aspects of TCM and medicine history. Some medicine historians propose the current era of healthcare systems to include strange discontinuities of quantum physics among healing methods (Carleton, 2005). However, since the participants were not informed about these issues, beyond the regulation aspects, these extreme healing methods could not be discussed.

Participants provided data only on the TCM practices about which they had information. Thus, this narrowed the scope of the data. For instance, I collected excessive information about acupuncture and very little about maggot therapy.

Finally, I as the researcher constituted another limitation to the study. In qualitative research, there is always the possibility of bias because of the high reflectivity between participants and researchers. The reflectivity implies that the researcher becomes part of the social world (s)he investigates (Berg, 2001). On the other hand, the qualitative researcher has to be aware

of this interaction between participants and him/herself. To avoid potential biases, researchers have to put distance between themselves and the data, alter the method of data collection, or analyze accordingly (Krefting, 1991).

I worked on ensuring reliability and avoiding potential biases of the research by triangulating data sources, participants, and timeframes of the study. My advisor also checked the analysis results, which provided some reliability to the findings. Furthermore, I had assistance from field experts, such as deontologists and TCM practitioners, in the data collection process.

However, I was a part of this process all the time. Therefore, there was a possibility of reflectivity between participants and me. Some of the participants approached me as if I were a representative of the Turkish Ministry of Health or would present the results to the Ministry of Health. Some participants asked me to present the results to the Ministry of Health (such as Participant ID # 25). Some participants talked in a manner that resembled speech-giving or media statements with sentences like "I want to thank our President for this regulation" (such as Participants ID # 2, 50, and 38).

Although I informed all participants about the ethical issues, some of them hesitated to reveal certain information during interview recordings and wanted to speak off the record. Although I tried to be neutral towards results, there is always a shadow of myself reflected in the study, by nature of the methodology. Furthermore, a majority of the interviews were held in participants' work places. Thus, there were patients, nurses, or other colleagues listening to the interviews in some cases, which created some amount of tension for the participants in revealing their ideas. Interviews held in private clinics created time pressure on the participants, which led them to speak generally without going into details.

A majority of the participants hesitated to talk about personal or ideological issues such as religion. Some participants implied that I must have information about some traditional practices such as cupping therapy because of my headscarf. Thus, they made statements like "Well, you'll also prefer the special days of hacamat" (Participant ID # 30) and were sure that I had experienced that practice. All these factors affected the quality of the data and created a bias as well.

Since TCM integration into the THCS is an evolving process, exact results of the process might be clearer in 5 to 10 years' time and the field may then provide more theoretical insights for future studies.

8.3. Future Study Suggestions

This study included only medical professionals of the THCS as participants. However, inclusion of other stakeholders of TCM integration, such as patients as users, may provide insights on legitimation processes. PNMDs, who have been the carriers of some traditional TCM practices, such as cupping therapy, can also be included in future research. Indeed, I conducted some interviews with users and PNMDs, but only for explorative purposes. Therefore, future research that includes these actors may provide theoretical opportunities for legitimation of a professionalized area by non-professionals. Moreover, the experiences of the users of TCM practices may worth to explore in near future which may enrich the legitimation conceptualization as well.

Another research alternative may be the theorization of the legitimacy of legitimacy criteria. In organizational fields, the criteria of legitimation may be highly contextualized. For example, in this study, some participants questioned 'religion' as a legitimacy criterion in the healthcare field. However, applications of the Prophet or of any religion as a whole may constitute the sole criterion in other research that studies the field of religious affairs. Therefore, the decision of what or who determines what are legitimate legitimacy criteria can be studied in future research.

The reason for TCM regulation is still unclear according to my observations of the field, although discovering it was not among the aims of this study. There might be reasons for the state to regulate TCM practices in the THCS. There may be some professionals who mobilized state authorities to regulate TCM practices, as well. What made the government regulate TCM practices and the exact reason for integrating TCM into the THCS may be worth studying. There may also be some professionals who mobilized the state towards regulation, acting as institutional entrepreneurs (Greenwood & Suddaby, 2006). The current data did not reveal clear information about these issues since the research was not designed to measure them. Therefore, these topics may be studied in the near future, as well.

My final suggestion about future studies of TCM integration is to design research in such a way that it will capture the institutional logics that the professionals have embedded. Institutional logics is defined as the socially constructed, historical patterns of material practices, assumptions, values, beliefs, and rules by which individuals produce and reproduce their material subsistence, organize time and space, and provide meaning to their

social reality (Thornton & Ocasio, 1999). Indeed, I tried to capture the embedded logic of professionals during analysis stages of this study; however, since the research was not designed to measure this, the excerpts of the participants revealing their dominant logics were blurred and messy. Therefore, I did not find it ethical to rely on inferences in that way and thus found it more reliable to rely on attribute coding.

However, there are well-developed logic measurement designs qualitatively, as well (Reay & Jones, 2016). Studying logics as the core construct of any study may reveal other combinations of legitimacy criteria in which institutional logics of professionals act as the determinant.

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APPENDICES

APPENDIX A. TERMINOLOGY DISPUTED IN HEALTHCARE AND THE TCM FIELD

There are different words used interchangeably in these fields and thus I summarize some key terms and their definitions. WHO definitions of TCM are given in Chapter 3.

Conventional medicine: This term is used in some WHO publications. The adjective has different meanings, though: it can refer to a formal convention (in international law, for instance) or an informal convention (socially, it is agreed that a certain practice is the most broadly accepted or most widespread). In both meanings, reservations may be expressed regarding the adjective (UNESCO, 2013). Who established the convention? In a societal sense, can this medicine be considered to represent a convention, regardless of the society?

Orthodox medicine: Arguments comparable to those above may be used. Orthodoxy (the 'right path') would refer to a 'legitimacy' that is not achieved strictly speaking in the field with which we are dealing here. Furthermore, the adjective also applies to specific movements within major religions and it is essential here to avoid any confusion (UNESCO, 2013).

Western medicine: The fact is that today's medicine was largely developed by researchers and clinicians living in the west. However, it has spread across the world and is practiced and recognized everywhere. It may also be noted that, as regards semiological observation and certain principles (of professional ethics and organization, for example), this kind of medicine descended from other medicines (Greek, Arab, eastern). More generally, it would be unsatisfactory to seem to be attributing it to one part of the world rather than others (UNESCO, 2013)

Scientific medicine: For the most part, modern medicine claims to be based on science. For 30 years now, much has been said and written about evidence-based medicine. However, there is general agreement now that this expression has a limitation in that quality health care is not confined to the application of "scientifically tested" techniques or medication (UNESCO, 2013).

Allopathic medicine: A term essentially used by practitioners of homeopathic medicine to describe medicine treating factors of illness by means that oppose them. It is rarely used outside of this context; therefore, it will not be used in this document (UNESCO, 2013).

Modern medicine: The broadest consensus was reached on this term. The following reasons were decisive: most of the scientific and technical discoveries regarding this kind of medicine were made in the modern era (the past two centuries). Some considered that it was questionable to 'contrast' the terms 'modern' and 'traditional', but we do not consider this to be the case: the meaning of 'traditional' here seems quite clear to all and 'modern' refers to a period, i.e. recent history, and does not imply any value judgment. Furthermore, we do not consider that it would suggest that more credit be given to one type of society or one part of the world (UNESCO, 2013).

Complementary and alternative medicine: The terms 'complementary medicine' and 'alternative medicine' are used interchangeably with 'traditional medicine' in some countries. Complementary/alternative medicine often refers to traditional medicine that is practiced in a country but is not part of the country's own traditions. As the terms 'complementary' and 'alternative' suggest, they are sometimes used to refer to healthcare that is considered supplementary to allopathic medicine. However, this can be misleading. In some countries, the legal standing of complementary/alternative medicine is equivalent to that of allopathic medicine, many practitioners are certified in both complementary/alternative medicine and allopathic medicine, and the primary care provider for many patients is a complementary/alternative practitioner (WHO, 2001).

Traditional medicine: Traditional medicine includes a diversity of health practices, approaches, knowledge, and beliefs incorporating plant, animal, and/or mineral-based medicines, spiritual therapies, manual techniques, and exercises, applied singly or in combination to maintain well-being as well as to treat, diagnose, or prevent illness (WHO, 2001).

Integrative medicine: Integrative medicine combines treatments from conventional medicine and TCM for which there is evidence of safety and effectiveness. It is also called integrated medicine (Sutton, 2010).

APPENDIX B. LEVEL OF HIERARCHY OF EVIDENCE

Level I: Evidence obtained from a systematic review of all relevant randomized controlled trials.

Level II: Evidence obtained from at least one properly designed randomized controlled trial.

Level III.1: Evidence obtained from well-designed controlled trials without randomization.

Level III.2: Evidence obtained from well-designed cohort or case-control analytic studies, preferably from more than one center or research group.

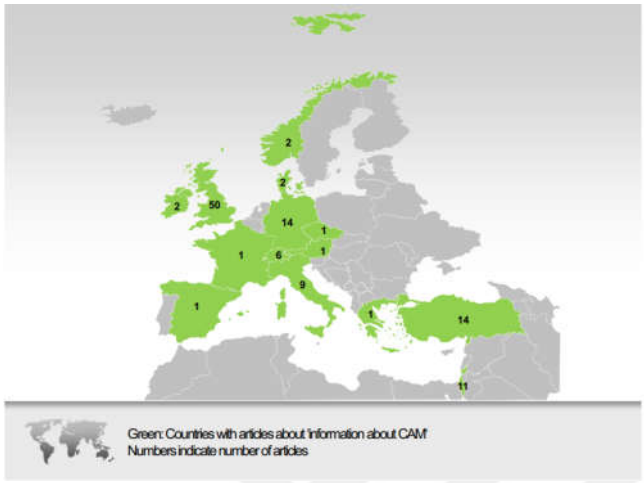
Level III.3: Evidence obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments (such as the introduction of penicillin treatment in the 1940s) could also be regarded as this type of evidence.

Level IV: Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees (Willis & White, 2005).

APPENDIX C. SOME EXAMPLE MAPS FROM CAMBRELLA REPORTS

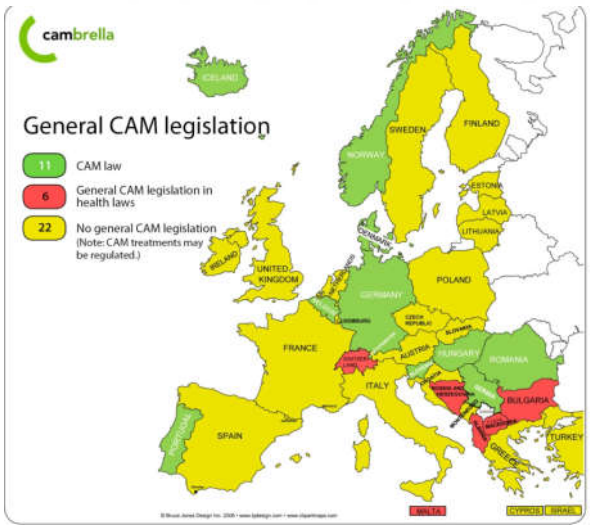
Map 1

Map of countries with articles that address issues concerning information about TCM (Nissen et al., 2012)



Map 2

General legislation of TCM practices (Wiesener et al., 2012)



APPENDIX D. REGULATED TCM PRACTICES AS OF MAY 2018 IN THE THCS

Acupuncture: A traditional Chinese medicine in which needles are inserted into the skin at points corresponding to parts and functions of the body mapped out in a system of meridians. The Chinese put these meridian points into a system, but acupuncture as a treatment was used in almost every ancient society in Asia, the Middle East, and Egypt (Navarra, 2004). The assessment of acupuncture application is based on historical and philosophical theories such as yin/yang (the complementarity of opposites) and the five elements (air, water, fire, earth, metal) to guide the diagnosis and treatment of patients (Crumley, 2012).

Apitherapy: Treatment that uses bee products including bee venom, royal jelly, bee pollen, raw honey, and propolis (Navarra, 2004). The history of apitherapy can be traced back to the ancient Egyptians, who used it as a treatment for arthritis (Ahuja & Ahuja, 2010). The use of honey has also been documented in several religious texts including the Veda (a book of Hindu scriptures) and the Bible, and 4000-year-old tablets record the use of honey in ancient Sumer (Ahuja & Ahuja, 2010). The Prophet Muhammed is also believed to have advised usage of honey as a therapy (Qureshi et al., 2017).

Chiropractic: An ancient treatment dating back to ancient Egypt, it is based on hands-on manipulation or adjustment of the spinal cord (Navarra, 2004). Modern chiropractic took root in the theory expressed in 1895 by Daniel Palmer, who claimed that illnesses have their roots in the spine and nervous system (Navarra, 2004). However, spinal manipulation is one of the oldest and most widely practiced healing methods and references to spinal manipulation can be traced back as far as Hippocrates and Galen (Meeker & Haldeman, 2002). Chiropractors work with the idea that the body has an inner intelligence and the ability to heal itself (Navarra, 2004). To obtain professional legitimacy chiropractors underwent several disputes and struggles in countries like the USA and Canada (Meeker & Haldeman, 2002; Sutton, 2010).

Homeopathy: A treatment system based on the theory that ‘like cures like’ and that if a substance causes a symptom, it can conversely cure it when taken in a highly diluted form or in minute quantities. Homeopathic remedies are made from plants, animals, or mineral sources. As a treatment homeopathy was developed by Samuel Hahnemann in the late 18th century, who focused on symptoms rather than causes (Navarra, 2004). Although systemized by Hahnemann, the homeopathic approach to treatment in terms of preparation of remedies

and strength of similarity in curing was mentioned by Hippocrates, and by Paracelsus as well (Bellavite, Conforti, Piasere, & Ortolani, 2005). According to Cant and Sharma (1996), homeopaths experienced a contested historical process from marginality to a legitimate professional position.

Music Therapy: The application of music by a qualified practitioner to induce positive changes in the psychological, physical, mental, or social functioning of the patient. Music therapy was used in the Selçuk and Ottoman healthcare systems, specifically for mental patients and in complementing other treatments as well. Turkish classical music contains different styles of music for musical therapy, each of which is applicable to different illnesses (Navarra, 2004). Music therapy is very old in Turkish history. According to historical records, 6000-8000 years ago, music therapy was used to treat anxiety and was applied during shamanic religious ceremonies by Uyghur and Altai Turks (Kabalak, 2017). According to historical records, specific Turkish classical music makams (which are specific compositions) are influential on some diseases (Kabalak, 2017). For example, for childhood diseases, the rast makam is effective on bones and the brain; it prevents too much sleep and is good for mental illness (Kabalak, 2017).

Reflexology: An energy-based healing method with similar attributes to acupuncture and massage that uses the soles of the feet as a map of the entire body's zones (Navarra, 2004). The practice has its roots in ancient civilizations; a wall carving in the tomb of Ankhmahor in Egypt, dated around 2500 BC, shows doctors working on patients' hands and feet, and traditional representations of the Hindu deity Vishnu are covered in symbols coinciding with reflex points (Lakasing & Lawrence, 2010). Although signs of this healing system were revealed in ancient cultures, it was systematized in the early 1900s by an American physician, Fitzgerald (Navarra, 2004). As a practice reflexology requires touch between the practitioner and the patient, which recognizes the interplay between psychosocial and physical factors in the genesis of illness (Lakasing & Lawrence, 2010). As a practice reflexology also accepts the importance of the balance of body liquids, which is related to yin/yang theory (Lakasing & Lawrence, 2010).

Osteopathy: Healing by manipulating bones and soft tissues to allow the free circulation of blood and lymph and to restore the nervous system to function 'normally'. Although osteopathy practitioners are known as 'bone-setters' in almost every culture, the practice derived its theoretical roots from the studies of Andrew Taylor Still (Navarra, 2004). The

founder of the therapy was not a medical doctor who viewed the musculoskeletal system as the vital mechanism of the body (Navarra, 2004). Thus, osteopaths observe patients to determine the causes of disease in a holistic way (Navarra, 2004) and refer to a distinct philosophy of this practice (Paulus, 2013). Although accepted as having developed within the last 150 years and experiencing competition in terms of legitimacy (Sutton, 2010), osteopathy became a legitimized medical profession in many countries including the USA, Canada, Germany, and Britain (Navarra, 2004; Sutton, 2010; Wiesener et al., 2012). In Turkey there are traditional bone-setters called 'sınıkçı' as well, although osteopathic practitioners do not accept their legitimacy in terms of osteopathic theory.

Hirudotherapy: Hirudotherapy is the application of medicinal leeches (Hirudo medicinalis) for therapeutic use. It is one of the oldest remedies, being employed by various medicinal practitioners. Hirudotherapy involves the attachment of cultured leeches onto affected areas. Leech therapy involves an initial bite, which is usually painless, followed by the sucking of 5 to 15 mL of blood. Its major therapeutic benefits are not only due to blood sucked during the biting, but also from various bioactive substances (Swaid, Latief, Rashid, & Tewari, 2012). Although hirudotherapy is not mentioned in any religious texts according to my research, in terms of categorization it is linked closely with cupping therapy because these two practices share the same core philosophy of bloodletting – the removal of bad substances or peccant humors (Baran, 2013; Hyson, 2005). Leeches have been used as an instrument to get rid of those substances throughout history. It was recorded that the first person who used leeches medicinally may have been Nicandros of Colophon (200-130 BC) (Munshi, Ara, Rafique, & Ahmad, 2008).

Prolotherapy: Prolotherapy is a method for strengthening lax ligaments. During prolotherapy, proliferating agents are injected directly into stretched or torn ligaments, resulting over a few weeks' time in the loss of pain in the affected area and return to normal function of the associated painful skeletal articulation. Following injection of the proliferating agent, the clinician observes an immediate localized inflammation, which diminishes gradually over several days (Banks, 1991). As a practice prolotherapy was used during the 1930s by several practitioners such as Hackett, Gedney, and Shuman. However, it was Hackett, an American practitioner doctor, who first used the word 'prolotherapy' (Hakala, 2005). Although the practice developed within the era of modern medicine and using medical substances, the idea behind it resembles ancient self-healing treatment

methods. Namely, inflammation initiates the biological process of wound healing (Hakala, 2005). On the other hand, injection of a chemical substance may lead to some side effects and complications, which is very rare in other TCM practices (Hakala, 2005).

Mesotherapy: Mesotherapy is a treatment method devised for controlling pain syndromes or diseases by subcutaneous microinjections given at or around the affected areas in short intervals of time (Nagore et al., 2001). The term 'mesotherapy' was suggested by Dr. Pistor in 1958 in France (Jacques, 2005). The idea of the practice is similar to prolotherapy as injection of chemicals leads to stimulation of the body and the practice has been used in aesthetics recently (Caruso, Roberts, Bissoon, Self, Guillot & Greenway 2008).

Maggot Therapy: Maggot debridement therapy is the intentional treatment of suppurative skin infections with the larvae of the fly Lucilia sericata. Today, this treatment modality is being used in over 30 countries and during the last 20 years, more than 60,000 patients have been treated in 2000 medical institutions. Sterile maggots, produced in university laboratories and by private industry, are usually applied to the wound either by using a cage-like dressing or a tea bag-like cage (Mumcuoğlu & Özkan, 2009). Historically, the effect of maggots on wounds was discovered by Ambroise Pare in the 16th century (Mumcuoğlu & Özkan, 2009). However, it was not before the 1930s that maggots started to be used systematically for wounds by Baer (Mumcuoğlu & Özkan, 2009; Tugcu et al., 2009).

Phytotherapy: Phytotherapy is the use of plants or plant extracts for medicinal reasons (Lowe & Ku, 1996). Despite this short and clear definition, phytotherapy includes a vast amount of literature and historical, geographical, and religious aspects.

First, according to hadith texts, it is believed by Muslims that the Prophet Muhammed advised the usage of some herbs in healing, such as black cumin, water of mushrooms, and oil of dill (T.C. Diyanet İşleri Başkanlığı [Diyanet], 2014).

Second, the regulation of herbal medicines has been a concern of many countries for years, which led the WHO to prepare reports on herbal medicines and countries to establish pharmacopeias[34] (Nissen, Johannessen, Schunder-Tatzber, & Lazarus, 2012; WHO, 2005; Zhang, 1998).

[34] An authoritative book containing a list and description of drugs and medicines together with the standards established by law for their production, dispensation, use, etc.

Lastly, herbal medicines include extracts, vitamins, or nutrition taken by people; thus, we can say that phytotherapy requires drug treatment, albeit not in all cases (Lowe & Ku, 1996).

Phytotherapy has a long history and has been used worldwide since the therapies demonstrate effects on immunology, inflammation, and cancer (Rao, Subash, & Kumar, 2012). The advantages of this TCM practice are relatively fewer side effects, unique mechanisms of action, and low cost (Rao et al., 2012).

Hypnosis: Hypnosis is defined as a key to the entrance of the subconscious mind and is one of the oldest treatment methods. Hypnosis is usually done with the help of a doctor using verbal repetition and mental images. When people are under hypnosis, they usually feel calm and relaxed, and are more open to suggestions. Hypnosis can be used to help to gain control over undesired behaviors or to help cope better with anxiety or pain (Erel & Erel, 2014).

Franz Anton Mesmer (1734-1815), a German physician, introduced hypnosis to the medical community in the late 18th century (Navarra, 2004). Mesmer's theory was that when magnetic forces existing in all matter become unbalanced, disease occurs, and he believed he could transfer his body's 'animal magnetism' to another through the use of magnets, iron rods, and 'mesmerizing', or highly soothing, verbal suggestions that induced a trancelike state (Navarra, 2004). Despite the healing potential of mind over matter and the deep relaxation states that emerged, including trances, Mesmer's theories could not be scientifically proven by a committee of investigators in the French medical community, among whom were the American statesman Benjamin Franklin and the French physician Josef de Guillotin, and Mesmer was branded a quack and banned from practicing in France (Navarra, 2004). In 1958 the American Medical Association officially recognized hypnosis; that recognition eventually led to the establishment of several professional associations, including the American Society of Clinical Hypnosis and the American Institute of Hypnotherapy, whose members are physicians, psychologists, dentists, and other health professionals (Navarra, 2004).

Ozone Therapy: Ozone therapy may be summarized as administering a particular amount of ozone/oxygen mixture into body cavities or circulation. The ozone/oxygen gas mixture can be applied via intravenous, intramuscular, intraarticular, intrapleural, intrarectal, and intradiscal routes as well as topically. Medically, ozone therapy was used during World War

I by A. Wolf in 1915 (Babucçu, 2011). The most frequent ozone administration is major autohemotherapy (Özler, Öter, & Korkmaz, 2009).

Cupping Therapy: There are two different methods of cupping in practice: wet cupping and dry cupping. Hacamat, also known as bloodletting or wet cupping therapy, is an alternative mode of treatment that relies solely on removal of subcutaneous blood (which is presumably the stagnant, toxin-containing blood), and hence is effective in treating many conditions including low back pain, acute gouty arthritis, asthma, cardiac arrhythmia, insomnia, neck pain, and migraine (Bilal, Khan, & Danial, 2015). In the dry cupping technique, a suctioning cup is placed over the painful area or a reflex zone, pulling the skin and underlying tissue into the cup (Al-Reefy & Parsa-Nezhad, 2014). Though the exact origin of cupping therapy is a matter of controversy, its use has been documented in early Egyptian and Chinese medical practices (Qureshi et al., 2017). The earliest recorded references to cupping therapy use are found in the Ebers Papyrus, written by Ancient Egyptians in hieroglyphics, from about 1550 BC (Qureshi et al., 2017). According to many Arabic sources, the Prophet Muhammed encouraged cupping therapy, with hadith stating “indeed the best of remedies you have is cupping” and “healing is to be found in three things including use of honey, cupping, and cautery (Qureshi et al., 2017). A different hadith states that “the Prophet used to have cupping done on the 17th, 19th, and 21st days of the lunar month” (Qureshi et al., 2017). It seems that the Prophet’s advice and his personal application of wet cupping (hacamat) are commonly accepted in hadith texts (Diyanet , 2014). Many theories describing the therapeutic mechanisms of cupping therapy have been put forward over the centuries of its practice. For example, shamans in primitive societies believed it to suck devils and infirmity from the body. Beliefs that cupping therapy extracts toxic or poisonous substances (detoxification) in the blood were promoted in ancient times and continue to be part of practitioners’ understanding of the practice today (Qureshi et al., 2017).

APPENDIX E. DISTRIBUTION OF FIRST ORDER CODES TO THE INTERVIEWS

1st order codes	1	2	3	4	5	6	9	10	11	12	13	14	16	17	18	19	20	21	23	24	25	26	27	28	29	30	31	32	33	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52
Commercial dimension (of TCM integration)	X	X	X	X	X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Health tourism in relation with TCM		X									X			X									X		X			X												X							X
Repertoir of the TCM practitioner																	X					X		X	X	X			X		X				X			X		X	X							
Financially benefical for the state budget	X	X								X			X			X		X			X												X					X	X									
Market / Brand/Economic Value of TCM practices	X	X																															X										X			X		X
(Non)Payment by social security for TCM practices						X			X	X															X																						
Payment made by patients for TCM practices																		X				X									X																
Demand of the public towards TCM					X	X	X															X			X													X						X				
Evidence-Based Research	X			X		X	X			X	X	X	X	X	X	X	X	X	X	X	X		X		X		X	X			X	X			X				X			X		X		X		
Scientific Research as Evidence		X		X	X					X			X			X	X		X	X	X				X				X	X	X		X	X	X	X	X	X	X	X		X	X	X	X	X	X	X
Fractions among TCM practices																																				X	X							X				
Documentation of clinical observations																			X												X	X												X				
Difficulty and Subjectivity of Measure of Tcm				X	X		X										X			X			X	X	X		X	X			X	X		X	X	X			X	X		X	X				X
Unique measurement methods specific to TCM practices				X													X																		X				X				X				
Perceived healing of the patients														X																	X	X	X	X	X			X		X			X			X	X	
Effectiveness of the results (of TCM)				X			X		X			X	X																		X	X	X	X		X		X	X	X			X		X	X	X	
(Inefficiency of) Modern medicine (problems)	X						X											X				X						X			X	X	X		X			X					X					
Validity													X	X																																	X
Safety																																											X				
Philosophy of the TCM practices					X																		X							X		X		X		X	X			X						X	
Power (Insufficiency) of Tcm Practices				X	X		X				X	X	X	X	X	X	X		X			X			X	X	X	X	X	X	X	X	X		X	X	X	X	X	X				X	X	X
Historical and Folkloric Value				X							X										X		X															X								X		X
Standard - unblemished historical background																														X					X												
Religious Dimension as an attribute	X	X		X	X			X			X		X	X	X			X	X			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Application of the Prophet																															X					X	X										
Exaggerated rhetoric in promotion																				X									X	X		X						X	X	X	X	X		X	X
Outcast examples																																													X		X
Bad past experiences															X		X		X								X		X		X	X															
Opponents' arguments	X					X		X				X			X		X	X			X	X			X	X	X	X	X	X	X		X	X	X		X	X	X	X		X			X	X	X
Field-wide consensus (among professionals and other stakeholders)	X																																												X	X	
Professional association's attitude (Construal of professional associations)	X			X	X				X		X		X	X	X	X		X	X	X	X	X					X		X	X	X	X	X									X		X	X	X	X
Other countries' approvals		X								X				X		X		X		X		X			X		X										X							X		X		
WHO Acceptance of TCM																									X									X									X			X		
Public Acceptance of TCM						X	X																		X									X									X		X			
Change in medicine field	X															X																																
Attitude change towards TCM																																		X				X				X			X		
Healthcare field information	X	X		X	X		X		X	X	X	X			X	X	X	X		X				X	X				X	X	X	X	X		X	X	X	X		X		X		X	X		
State Regulation (Political support)	X	X	X	X	X	X	X	X	X	X		X		X	X	X	X	X	X	X	X		X	X		X	X	X		X	X	X	X	X	X	X	X		X	X	X	X	X	X	X	X	X	X
State Politics	X	X											X	X	X	X							X	X		X	X	X	X	X	X		X					X		X	X	X	X				X	X
Authority of the practitioner						X													X							X				X					X	X			X		X	X	X	X		X	X
Competition among professionals						X					X						X				X												X	X	X	X	X	X	X	X		X		X	X	X	X
Doctors' choice of treatment																																			X									X			
Comfort of the practitioner																									X								X							X					X		
Quality of the TCM field																																						X		X		X	X	X	X	X	
Equilibrium to emerge in TCM field																																						X				X	X	X		X	
Competence of the practitioner																																						X				X	X			X	
Quality of the practitioner (of TCM)																																						X								X	
Education and Training	X			X		X	X		X		X	X	X	X	X		X	X	X	X		X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
Quality of the education and educators (of TCM)				X																										X			X		X			X									
Liberty of training of TCM	X																																										X				
Harmless	X	X	X	X	X		X						X	X				X	X				X		X	X	X	X				X	X				X	X		X	X		X				X

APPENDIX F DISTRIBUTION OF PARTICIPANT PROFESSIONALS ACCORDING TO THEIR PROFESSIONAL PROFILES

Interviewee ID	Profile	Occupation	TCM Practitioner?
1	Profile 1	Medical doctor	Yes
2	Profile 1	Physiotherapist	No
3	Exceptional	Medical doctor	Yes
4	Profile 1	Medical doctor	Yes
5	Profile 2	Medical doctor	No
6	Profile 1	Medical doctor	Yes
9	Profile 1	Medical doctor	Yes
10	Profile 1	Medical doctor	Yes
11	Profile 2	Medical doctor	No
12	Profile 1	Medical doctor	No
13	Profile 2	Medical doctor	No
14	Exceptional	Pharmacist	Yes
16	Profile 2	Medical doctor	No
17	Profile 2	Medical doctor	No
18	Profile 1	Medical doctor	Yes
19	Exceptional	Pharmacist	No
20	Profile 1	Medical doctor	Yes
21	Profile 1	Dentist	Yes
23	Exceptional	Medical doctor	Yes
24	Profile 1	Medical doctor	Yes
25	Profile 1	Medical doctor	Yes
26	Profile 1	Medical doctor	Yes
27	Profile 2	Medical doctor	No
28	Profile 1	Medical doctor	Yes
29	Exceptional	Medical doctor	Yes
30	Profile 1	Medical doctor	Yes
31	Profile 1	Medical doctor	Yes
32	Profile 1	Medical doctor	Yes
33	Exceptional	Medical doctor	Yes
35	Exceptional	Medical doctor	Yes
36	Profile 1	Medical doctor	Yes
37	Exceptional	Medical doctor	Yes
38	Profile 1	Medical doctor	Yes
39	Profile 1	Medical doctor	Yes
40	Profile 1	Medical doctor	Yes
41	Profile 1	Pharmacist	Yes
42	Profile 1	Medical doctor	Yes
43	Exceptional	Medical doctor	Yes
44	Exceptional	Medical doctor	Yes
45	Profile 1	Medical doctor	Yes
46	Exceptional	Dentist	Yes
47	Profile 1	Medical doctor	Yes
48	Exceptional	Medical doctor	Yes
49	Exceptional	Medical doctor	Yes
50	Exceptional	Medical doctor	Yes
51	Profile 1	Medical doctor	Yes
52	Profile 2	Medical doctor	No

APPENDIX G DISTRIBUTION OF PARTICIPANT PROFESSIONALS ACCORDING TO THE LEGITIMACY CRITERIA THEY USE DEPENDING IN DIFFERENT TCM PRACTICES

Corresponding Legitimacy Dimension	Legitimacy Criteria	TCM Bundle as a whole	Acupuncture	Cupping Therapy	Hirudotherapy	Phytotherapy	Hypnosis	Homeopathy	Music Therapy	Prolotherapy	Mesotherapy	Ozone Therapy	Osteopathy	Chiropractic	Apitherapy	Reflexology	Maggot Therapy
Normative	Effectiveness of the results (of the	4,9,11,14,16, 37,38,41,43,44,45,47,49	16, 36, 37, 39, 43, 47, 50,51	16, 36, 37, 43, 50	16, 37, 50	14, 37	43	44	50		36, 50		45, 51	45	47		
Normative	Harmless (treatment)	1,2,3,4,5,9,16,17,23,27, 29,31,32,46,52	1, 4, 23, 29, 30, 31, 37,38,43	27, 42, 43, 30, 31, 37, 38	27, 30, 38	30, 21				35	35, 52	30, 38	45	27			
Normative	Safety	48															
Normative	Validity	16,17, 37, 45, 52															
Normative	Doctors' choice of	40, 49															
Regulative	State's regulatory recognition	1, 2, 3, 4, 5, 9, 11,12,17,18,20,21,23,24 27, 28, 30, 31, 32, 37, 38 39	25, 30, 35	10, 30, 36, 42	30, 43, 50	14, 19	42, 43	37, 44	17, 50, 52	20	20, 30, 38, 49, 50	20, 38, 49	45, 51	51			
Regulative	WHO acceptance	25, 29,39,47,50	25, 29, 50	30													
Moral	National	4,13,27,41,43	18,23,25						50, 52								
Moral	Application of the			10,37,42,43		2, 42											
Moral	Philosophy of the treatment	5,27,35,41	1, 26, 35, 39, 45		43		42	37, 44			51		45				
Pragmatic	Economic value	1,2,47,50,52	1			2, 16		11		35	35	38					
Pragmatic	Expensive / Cheap for	1,2,12,16,21,38,43,44	1, 2, 25			2, 16, 19		11 ,44				38					

APPENDIX H. TEZ FOTOKOPİ İZİN FORMU

ENSTİTÜ

Fen Bilimleri Enstitüsü ☐

Sosyal Bilimler Enstitüsü ☐

YAZARIN

Soyadı :
Adı :
Bölümü :

TEZİN ADI (İngilizce) :

TEZİN TÜRÜ : Yüksek Lisans ☐ Doktora ☐

1. Tezimin tamamından kaynak gösterilmek şartıyla fotokopi alınabilir. ☐
2. Tezimin içindekiler sayfası, özet, indeks sayfalarından ve/veya bir bölümünden kaynak gösterilmek şartıyla fotokopi alınabilir. ☐
3. Tezimden bir bir (1) yıl süreyle fotokopi alınamaz. ☐

TEZİN KÜTÜPHANEYE TESLİM TARİHİ

APPENDIX I. TURKISH SUMMARY

Giriş

Olgucu, gerekirci, indirgemeci ve nesnelci yaklaşımları benimseyen modern tıp anlayışı 19. yüzyıl ortalarında başlayan ve 20. yüzyılda da devam eden süreçte sağlık sistemlerine hakim olmuş (Coulter, 2003); bu yaklaşımların dışında kalan bazı geleneksel ve tamamlayıcı tıp uygulamaları (GTTU) ise ülkelere ve zamana göre farklılık göstermekle birlikte sağlık sistemlerinin dışında kalmıştır (Ebrahimnejad, 2008; Saks, 2005). Türk Sağlık Sistemi' de (TSS) 19. Yüzyılda Osmanlı dönemi modernleşmesi ile başlayan ve Cumhuriyetin ilanı ile devam eden, benzer bir nesnelleşme ve batılılaşma süreci yaşamıştır (Ceylan, 2012; Günergün, 2013).

Öte yandan, bazı GTTU son yıllarda sağlık sistemlerine giriş yapmaya ve sisteme eklemlenmeye başlamıştır (Broom & Tovey, 2007; Goldstein, 2002; Mizrachi, Shuval, & Gross, 2005). Dünya Sağlık Örgütü'nün (DSÖ) 1978'den beri konuyla ilgili yayımladığı raporlar mevcuttur. DSÖ, 2002 den beri yayımladığı iki adet rapor ile üye ülkelere, mevcut mevzuatlarında GTTU'nı içerek şekilde yenileme yapmaları yönünde çağrı yapmış ve pek çok ülke bu çağrıya uymuştur (WHO, 2014).

Türkiye'de GTTU konusunda dünyadaki sürece benzer bir süreç yaşamaktadır. Resmi olarak 1991 yılında akupunktur uygulamasının düzenlenmesi ile başlayan süreç, 2014 yılında 'Geleneksel ve Tamamlayıcı Tıp Uygulamaları Yönetmeliğinin' yayımlanması ile düzenlenen 15 farklı uygulama ile devam etmiştir. Yönetmelik içerik itibariyle, her bir uygulamanın tedavi amaçlı olarak hangi durumlarda kullanılacağını açıklayan endikasyon listelerini ve eğitim standartlarını içermektedir. Ayrıca uygulamaların yapılacağı ünite ve merkezler ile eğitim verilecek mekânlar ile ilgili standartlar da düzenlenmiştir. Yönetmelik ile düzenlenen 15 GTTU'sını uygulama yetkisi sadece tıp doktorlarına ve bazı yardımcı sağlık personeline verilmiştir.

Düzenleme aşamasında ve sonrasındaki süreçte, TSS'ndeki profesyoneller arasında GTTU'nın meşruiyeti konusunda bazı tartışmalar başlamıştır. Sağlık alanı içerisinde yönetmeliği destekleyenler olduğu gibi, bu düzenlemeye ve düzenlenen uygulamalara itiraz edenlerde vardır. Örneğin Türk Tabipleri Birliği (TTB) bu yönetmeliğin iptali için bir dava açmıştır. Düzenlenen uygulamaları uygulayan ve destekleyen veya tek başına düzenlemeyi destekleyenler de olmuş, bu konuda her görüşten yayınlar yapılmıştır.

Neticede, söz konusu düzenleme sağlık profesyonelleri arasında GTTU'nın meşru birer tedavi yöntemi olup olmadıkları konusunda bir bölünme oluşturmuştur. GTTU'nın meşruiyeti konusunda profesyoneller arasındaki bu tartışma, profesyonellerin birçok meşruiyet kriterini kullanarak çeşitli GTTU'nı farklı şekillerde değerlendirmeleri ile devam etmektedir.

Suchman (1995) tarafından bir örgütsel alana dair bir faaliyet, nesne ya da uygulamanın sosyal olarak inşa edilmiş normlar, değerler, inançlar ve tanımlar sistemi içerisinde arzu edilir, uygun ve kabul edilebilirliğine ilişkin genel algı ve varsayım olarak tanımlanan meşruiyet kavramı, örgütsel yazının ana konularından biri olarak görülür (Deephouse, Bundy, Tost, & Suchman, 2017; Suddaby, Bitektine, & Haack, 2017).

Meşruiyetle ilgili daha önce yapılan çalışmaların hemen hepsi, meşrulaştırılan bir öznenin, belirli bazı kriterler ya da tek bir kritere dayanarak değerlendirilmesi sürecini anlatır. Öte yandan, bu çalışmaların çoğunluğu meşrulaşmanın tek bir boyutunu incelemektedir. Mesela bu çalışmaların bazıları, sadece, genellikle yeni bir ürün olan meşrulaştırılma öznelerine odaklanır (Fisher, Kotha, & Lahiri, 2016; Navis & Glynn, 2010). Meşrulaştırılan özne bu çalışmalarda alanla alakalı tek ve homojen bir uygulama, ürün ya da örgütsel form olmaktadır. Öte yanda, meşrulaştırılan özne(ler)in birbirinden farklı bir uygulamalar kümesi olma ihtimali pek çalışılmamıştır.

Diğer bazı meşrulaşma çalışmaları ise tek bir meşruiyet kriterinin ele alındığı (yasal meşruiyet gibi) ve ele alınan bu kriterinde daha önce tanımlanmış, yasal, normatif ya da bilişsel meşruiyet olduğu çalışmalardır (Dobrev, 2001; Ruef & Scott, 1998; Vaara, 2014). Her ne kadar birden fazla meşruiyet kriterinin bir arada ele alındığı (Fisher, Kuratko, Bloodgood, & Hornsby, 2017; Laïfi & Josserand, 2016) ya da çevresel meşruiyet gibi farklı meşruiyet kriterlerinin çalışıldığı (Bansal & Clelland 2004) çalışmalar olsa da, bu çalışmalarda da meşruiyet kriteri boyutunun diğer boyutlarla ele alınmadığını görürüz.

Son olarak, meşrulaşma ile ilgili daha önce yapılan çalışmalarda eğer profesyoneller meşruiyet değerlendirmesi yapanlar olarak ele alınmış iseler, çoğunlukla birbirine benzeyen ve aynı normatif kriterler ile meşruiyet değerlendirmesi yapan bir grup olarak ele alınmışlardır. Profesyoneller arası bölünmelerin meşruiyet sürecini nasıl şekillendireceği ya da onların normatif meşruiyet dışında da bir kriter kullanabileceğine dair çalışmalara pek rastlanmaz.

Benim bu çalışmadaki amacım, meşrulaşma sürecini, meşrulaştırılan özneleri (uygulamalar ya da örgütsel formlar gibi), meşruiyet kriterlerini (yasal ya da normatif meşruiyet gibi) ve meşruiyet değerlendirmesi yapanları (meslek erbabı ya da devlet gibi) içeren çok boyutlu bir süreç olarak incelemektir. Meşrulaşmayı çok boyutlu olarak ele almak, tek boyutlu ele almanın neden olabileceği potansiyel yanlılık gibi engellerden kurtulmayı sağlayabilir. Ayrıca, yine meşrulaşmayı çok boyutlu ele almak sürecin tüm karmaşıklığının ve bazı kritik dinamiklerinin incelenmesini sağlayabilir. Özellikle bu çalışmada meşrulaştırılan özne olarak GTTU'nı, meşruiyet değerlendirme yapanlar olarak profesyonelleri ele aldım. Diğer bir boyut olarak ise profesyoneller tarafından GTTU'nı değerlendirirken kullanılan kriterleri ele aldım.

Kuramsal amacım olan, meşrulaşmanın çok boyutlu bir süreç olarak inceleneceği bir modeli oluşturabilmek için TSS'ndeki profesyoneller ile yaptığım yarı yapılandırılmış mülakatlardan ve bazı ikincil veri kaynaklarından oluşan bir veri seti ile çalıştığım nitel bir araştırma yürüttüm. Veri setine yapılan bazı kodlamalar ile tamamlanan analiz süreci, bana meşrulaşma sürecinin nasıl yürüdüğünü açıklayan ve başlangıçta belirttiğim üç boyut arasındaki etkileşimler ile şekillenen, bazı mesleki profillerin ön plana çıktığı bir model sundu.

İlerleyen bölümlerde çalışmaya esas oluşturan meşruiyet yazının taraması ve mevcut olası kuramsal fırsatlar anlatılacak, çalışmanın görgül bağlamı hakkında bilgi verilecektir. Ayrıca araştırmanın yöntemi, yapılan analiz ve bulgular ile açıklanacaktır. Son olarak bulguların tartışılması sunulacak ve çalışmanın kısıtlarını, bazı pratik katkılarını ve gelecekte yapılabilecek araştırma fırsatlarını açıklayan sonuç kısmı ile özet bölümü tamamlanacaktır.

Kuramsal Çerçeve

Tanımlar

Suchman (1995) tarafından yapılan meşruiyet tanımı (yukarıda belirtilen) yazında en sık kullanılan ve kavrama dair çalışılması muhtemel hemen hemen bütün kavramsal meseleleri içeren bir tanımdır.

Buna göre meşruiyet kavramının ilk ana meselelerinden birisi meşruiyetin boyutlarıdır. Meşruiyet boyutları yazında meşruiyet türleri ya da kategorileri olarak tanımlanmıştır (Suddaby vd., 2017). Buna göre tanımlanmış olan en yaygın meşruiyet boyutları yine

Suchman'a aittir. Suchman (1995) faydacı meşruiyeti izleyenlerin çıkarlarına, ahlaki meşruiyeti normative uygunluğa, bilişsel meşruiyeti ise kanıksanmış olmaya dayandırmıştır. Benzer bir kategorizasyonu aynı yıl yapan Scott (1995) ise, bu kez kurumsal uyum mekanizmalarına dayandırdığı meşruiyet boyutlarını; yasalar ve yaptırımlara dayalı yasal meşruiyet, ahlaki değerlere dayalı normatif meşruiyet ve yine kanıksanmışlığa dayandırdığı bilişsel meşruiyet olarak tanımlamıştır. Bunların dışında da tanımlanmış başkaca meşruiyet boyutları mevcuttur. Örneğin Archibald (2004) tarafından normatif ve bilişsel meşruiyetin bir araya getirildiği yeni bir kategori olarak kültürel meşruiyet, profesyonel bağlamların kültürel kabulü olarak tanımlanmıştır.

Boyutlar dışında, meşruiyet tanımı, meşruiyetin bir hal ya da süreç olarak çalışılmasını içerir. Buna göre (Deephouse vd., 2017) meşruiyetin dört farklı halini kabul edilebilirlik, uygun, tartışmalı ve gayri meşru olarak tanımlamışlardır. Ancak yazın meşruiyetin farklı hallerinin sürdürülemez olduğunu ve güçlü bilişsel bazı dinamiklerin süreci meşru-gayrimeşru düzleminde bir noktaya iteceğini kabul eder (Deephouse & Suchman, 2008). Diğer bir akım ise meşruiyeti bir süreç olarak kabul etmektir. Meşrulaşma süreci meşruiyet öznesinin meşruiyetinin zaman içinde değişmesi olarak tanımlanır (Ashforth & Gibbs, 1990). Buna göre gayri meşrulaştırma zaman içinde meşruiyet öznesinin uygun olmayan ve kabul edilemez bir hale geçmesi olarak kabul edilir.

Meşrulaşma süreci daha önce de söylendiği gibi meşrulaştırılan özneleri, meşruiyet kriterlerini ve meşruiyet değerlendirmesi yapanları içeren bir süreçtir.

Meşruiyet öznesi, örgütsel bir form, yapı, verilen bir karar, strateji, uygulama, ürün ya da hizmet gibi örgütsel alana dair herhangi bir şey olabilir. Yazında sıklıkla çalışılan meşruiyet özneleri, yeni bir ürün ya da hizmet (Lounsbury & Crumley, 2007; Navis & Glynn, 2010) ya da verilen bir karar ile gelişen bir girişimcilik süreci (Vaara & Tienari, 2008) şeklinde olmaktadır. Sıklıkla bu özneler homojen bir uygulama ya da ürünü betimler.

Meşrulaşma sürecinin diğer bir meselesi de meşruiyet değerlendirmesini yapanlardır. Yazında sıklıkla çalışılan meşruiyet değerlendirmesini yapanlar devlet, profesyoneller, uzmanlar, tüketiciler ya da toplum şeklindedir. Profesyoneller yani belirli bir mesleğe ait soyut bilginin pratik uygulayıcıları (Abbott, 1988) daha önce de belirtildiği gibi genellikle yazında normatif meşruiyet boyutu ile meşruiyet değerlendirmesi yaptığı kabul edilen bir gruptur (Ruef & Scott, 1998). Normatif meşruiyet ise herhangi bir meşruiyet öznesinin

profesyoneller ya da onların örgütleri tarafından onaylanmış olması anlamına gelir (Scott vd., 2000).

Meşrulaşma sürecinin son meselesi ise meşruiyet kriterleridir. Deephouse vd.,(2017) meşruiyet kriterlerini meşruiyet değerlendirmesine dayanak olan standartlar olarak tanımlamıştır. Scott'a göre (1995) kurumsal mekanizmalar ile meşruiyet kriterleri uyumludur. Yazında temel olarak çalışılan kriter türleri yasal, normatif, ahlaki ve bilişsel meşruiyet kriterleridir. Buna göre yasal meşruiyet, devlet tarafından tanınma ve onaylanma (Dobrev, 2001; Kwiek, 2012; Scott vd., 2000); ahlaki meşruiyet, sosyal sorumluluk projelerine destek verme gibi ahlaki değerler ile uyumlu olma (O'Neil & Ucbasaran, 2016) şeklinde çalışılmıştır. Bilişsel meşruiyet ise kurumsalcı akım tarafından kanıksanmışlık ile (Scott,1995), örgütsel ekoloji akımı tarafından ise yayılma (Rossman, 2014) ve yoğunluk ile ilintilendirilmiştir (Carroll & Hannan, 1989). Daha önce de belirtildiği gibi normatif meşruiyet profesyonel onaylama ile ölçülmüştür (Scott, vd., 2000). Bununla beraber, son yıllarda yapılan bazı çalışmalarda profesyonellerin pazar meşruiyeti (Bicho vd., 2013) ya da yetkinlik meşruiyeti (Sanders & Harrison, 2008) gibi normatif kurallara bağlı olmayan kriterler kullandığı da görülmüştür.

Yazında farklı meşruiyet kriterlerinin bir araya getirilip yeni bir kriter tipinin çalışıldığı da olmuştur. Ya da aynı değerlendirme sürecinde meşruiyet değerlendirmesi yapanlar birden fazla kriteri kullanabilmektedirler. Bu tarz durumlar meşruiyet tartışmalarının yaşandığı senaryolar olarak tanımlanmıştır (Deephpuse vd., 2017).

Meşruiyet yazını temel olarak meşruiyetin boyutlarını, kriterlerini, meşruiyet öznelerini ya da meşruiyet değerlendirmesi yapanları tek başına ele alıp, yeni bir inovasyon, ürün ya da hizmetin alana kabul ettirilmesi senaryolarını çalışmaktadır.

Az sayıdaki çalışma (Fisher vd., 2017; Laïfi & Josserand, 2016) birden fazla boyutu bir araya getirip meşrulaşmayı çalışmış olsa da bu çalışmalarda da bu boyutlar arasındaki etkileşimler göz ardı edilmiştir. Ayrıca meşruiyet öznesinin ya da değerlendirme yapanların hep homojen bir grup olarak ele alındığını görürüz.

Hâlbuki meşruiyet değerlendirmesi yapanların kendi aralarındaki bölünmüşlükler meşrulaşma sürecini etkileyebilir. Yine meşruiyet öznesinin tek bir ürün, hizmet ya da uygulama olmadığı, hatta yeni olmayıp daha önce bilinen ancak zamanla alanın dışında kalmış, şimdi ise alana yeniden eklemlenen uygulama ya da uygulamalar bütünü olma

ihtimalleri yeterince gözlemlenmemiştir. Buna göre, bu çalışmada meşrulaşma süreci çok boyutlu bir şekilde incelenecek ve ortaya çıkarılacak modelin yaratacağı kuramsal fırsatlar tartışılacaktır.

Çok Boyutlu bir Süreç Olarak Meşrulaşma

Yakın zamanda da teşvik edildiği üzere (Deephouse vd., 2017) meşrulaşma sürecini çok boyutlu ve bu boyutlar arasındaki etkileşimler ile hareket eden bir süreç olarak tanımlamak tek boyutlu olarak çalışmanın ortaya çıkarabileceği bazı riskleri bertaraf edebilir. Bu riskler (1) Potansiyel yanlılık, (2) Sürecin bazı kritik dinamiklerinin göz ardı edilmesi ve bu nedenle de sürecin mevcut karmaşıklığının anlatılamaması, (3) Meşrulaşmanın çok boyutlu biz düzlemde sürekli problemli bir süreç olacağının göz ardı edilmesi olarak sıralanabilir.

İşte meşrulaşmayı çok boyutlu olarak çalışmak, tek boyutlu çalışmanın ortaya çıkaracağı bu riskleri ortadan kaldırabilecektir.

Potansiyel yanlılıktan kast ettiğimiz, meşrulaşma sürecinde sadece tek bir boyuta odaklanmanın diğer boyutların sürece ve varsa başka boyutlara nasıl nüfuz edebileceğinin gözden kaçılması olarak tanımlanabilir. Örneğin, bazı araştırmacılar yeni bir uygulamanın alanda meşrulaşması için sayısal olarak yayılmasını ve çoğalmasını baz alırlar (Carroll & Hannan, 1989). Sayısal yayılmanın da, yeni uygulamanın mevcutlar ile olan benzerliği ya da büyük firmalar tarafından kabul edilmiş olması ile alanda çoğalması olarak belirlerler. (Mazza & Alvarez, 2000). Diğer bir bakış açısında ise meşrulaştırılma konusu uygulamanın toplum tarafından kanıksanmışlığı baz alınmış ve medya görünürlüğü ile ölçülerek meşrulaşması çalışılmıştır (Vaara, 2014; Vaara vd., 2006). Halbuki meşrulaştırılmaya çalışılan uygulamayı değerlendirenlerin birbirlerinden farklı olmaları, ürünü değerlendirmek için farklı meşruiyet kriterleri kullanıyor olmaları ihtimali her zaman mevcuttur. Ayrıca sadece yeni bir ürün değil, daha önce söylendiği gibi, alanın oluşumu esnasında dışında kalmış ve şimdi yeniden alana eklemlenen bir ürün ya da uygulama da meşrulaşma konusu olabilir.

Sadece tek bir ürüne odaklanma değil, meşrulaşma sürecinde sadece meşruiyet kriterlerini keşfetmek (Sanders & Harrison, 2008; Bansal & Clelland, 2004) üzere yapılan çalışmalarda yanlılık ihtimali taşımaktadır. Sadece meşruiyet kriterlerine odaklanmak (ki bu aynı zamanda diğer bir yanlılık riski olan tek bir meşruiyet değerlendiriciye odaklanmak

anlamına da gelebilir) birden fazla meşruiyet kriterinin aynı meşrulaştırma sürecinde hareketlendiği durumları açıklamamaktadır.

Son olarak sadece meşruiyet değerlendirenlere odaklanma ve odaklanılan değerlendiricileri birbirine benzer ve aynı şekilde meşruiyet değerlendirilenler olarak kabul etme, görgül alandan çıkarılması muhtemel başka meşruiyet kriterlerini kısıtlayabilir. Bu durum aynı zamanda değerlendiricilerle ilgili kuramsallaştırmaları da engelleyebilir. Genel olarak yazında meşruiyet değerlendirmesi yapanların devlet ve profesyoneller olduğunu söylemiştik. Mesela devtlet pekçok çalışmada sadece yasal meşruiyet sağlayıcı olarak çalışılmıştır (Dobrev, 2001; Kwiek, 2012; Scott vd., 2000). Öte yandan devletin yasal meşruiyet dışında başka bir kriter ile meşruiyet değerlendirme yapması ihtimali pek fazla çalışılmamıştır. Benzer şekilde profesyonellerin normatif meşruiyet kriteri ile meşruiyet değerlendirmesi yaptıkları öylesi kabul görmüştür ki, bazı kaynaklar normatif değerlendirme yapan başka aktörlerin ihmal edildiğini söylerler (Deephouse & Suchman, 2008).

Sadece tek bir boyuta odaklanma değil, kritik bazı dinamiklerin ihmali de meşrulaşmanın tek boyutlu çalışılmasının bir sonucudur. Kritik dinamiklerden kastımız meşrulaşmanın farklı boyutları arasındaki (Örneğin uygulama-kriter; değerlendiren-uygulama ya da değerlendiren-kriter gibi) olası etkileşimlerin göz ardı edilmesidir. Örneğin meşrulaştırılacak öznelerin birbirinden farklı uygulamalar kümesi olması ihtimalini ele alırsak; bir uygulama için geçerli olan bir meşruiyet kriteri bir diğeri için anlamsız olabilecektir. Eğer bir meşrulaşma süreci farklı boyutlar arasındaki bu tarz etkileşimler göz ardı ederse sürecin tam olarak açıklanamadığını görebiliriz. Ayrıca henüz ortada olmayan kriterlerin keşfedilme fırsatı da kaçırılmış olunur.

Neticede meşrulaşmayı sadece uygulamalara, kriterlere ya da değerlendirme yapanlara odaklanarak çalışmak yanlılık riskini ortaya çıkaracaktır. Ayrıca bu boyutlar arasındaki etkileşimleri ele almadan süreci anlamaya çalışmakta sürecin karmaşıklığının göz ardı edilmesine neden olacaktır. Meşrulaşma çok boyutlu bir düzlemde, çoğunlukla sorunlu olarak, bir defa da karara (meşrudur ya da gayrimeşrudur şeklinde) bağlanıp geçilemeyen bir süreçtir. Bunu anlayabilmenin en iyi yolu da çok boyutlu bir meşrulaşma modeli ortaya koymak olacaktır.

Son dönemde çok boyutlu meşrulaşma çalışan bazı yazarlar da olmuştur. Mesela, Fisher vd., (2017) meşruiyet değerlendirmesi yapan farklı grupların, değişik meşruiyet kriterlerini bir

araya getirdiklerini açıklamaktadır. Her ne kadar, birden fazla meşruiyet kriterinin varlığı kabul edilmiş olsa da; bu çalışmada da aynı grubun içindeki değerlendiriciler homojen kabul edilmiş, aralarındaki olası bölünmelerin süreci nasıl şekillendireceği irdelenmemiştir. Sonuçta meşruiyet değerlendirmesi yapılan yine tek bir 'yeni teknolojik ürün' dür Fisher vd., (2017).

Sonuç olarak, ben bu çalışmada meşrulaşma sürecini bütün karmaşıklığı ve problemleri ile anlayabilmek için onu çok boyutlu bir şekilde incelemeyi hedefliyorum. Meşrulaşmanın birbirinden farklı ve hepsi yeni olmayan uygulamaların yer aldığı bir kümenin meşrulaşma öznesi olduğu, birden çok meşruiyet kriterinin hareketlendiği ve profesyoneller arasındaki bazı mesleki bölünmelerin (kriter seçimler ve meşruiyet özneleri ile ilgili olmasa da) süreci belirlediği bir şekilde ele alıyorum.

Kuramsal olarak açıklamak istediğim modeli gözlemleme şansı vereceğimi düşündüğüm görgül bağlamı bir sonraki iki bölümde özetleyeceğim.

Sağlık Alanlarında Değişim

Bu çalışmada benim kullanmayı tercih ettiğim ismi ile modern tıp, yani modern zamanların sağlık sistemlerine, tıp eğitimlerine ve tedavi metotlarına yön veren, bilimsel ve olgucu tıp sistemi, pek çok tıp tarihçisine göre 18. Yüzyıl Avrupa'sında aydınlanma çağı ile ortaya çıkmıştır (Bayat, 2010; Çelik, 2013; Ebrahimnejad, 2008; Goldstein, 2002). Hastalıklara sebep olan şeyin, mikrop adı verilen küçük mikroorganizmalar olduğunun kabulü ile tıp sistemlerinde yüzyıllardır kabul gören diğer anlayışlar, yerlerini insan vücudunun laboratuvarda ve bütün değil parçalar halinde incelendiği bir tıp anlayışına bırakmıştır (Bayat, 2010; Coulter, 2003; Ebrahimnejad, 2008).

Modern tıbbın sağlık sistemlerine hâkim olması ile, 19. yüzyıldan bu yana, modern tıp profesyonelleri mesleki bağımsızlık kazanan en güçlü meslek grubu olarak kabul edilirler (Brosnan, 2015). Freidson (1988)' e göre tıp mesleğinin sahip olduğu güvenilir ve standart bilgi, toplum nezdinde güven ve meşruiyetinin kaynağı olmuştur. Böylece standart olma, herhangi bir bilginin tıbbi meşruiyeti için ilk kriter olarak belirmiştir (Mizrachi, 2002).

Bununla beraber ilgili yazın, (Adams, 2007; Cant & Sharma, 1996) tıbbi tedavilerin meşruiyeti için diğer bazı kriterleri şöyle belirlemiştir:

(1) Hastalar kullanımı ile yapılan klinik ölçümler

(2) Bilimsel yöntemle ölçülebilir olma

(3) Standart bir eğitim ve bilgi aktarım sisteminin var olması (eğitim meşruiyeti)

(4) Devlet tarafından kabul edilmiş olması (Politik meşruiyet)

Dolayısıyla modern tıbbın dayanağı olan bilimsel paradigma herhangi bir tedavi metodunun meşruiyeti için en geçerli kaynak olarak belirlenmiştir denebilir. Buna rağmen, 20. yüzyıla gelindiğinde, modern tıp profesyonellerinin gücünü, yetki ve yetkinliğini sorgulayan bazı dalgalar görülmeye başlanmıştır (Goldstein, 2002; Mizrachi vd., 2005).

Modern tıbbın, şeker ve tansiyon gibi bazı kronik hastalıklarda veya bazı kanser türlerinde başarısız olması, ülkelere göre değişen sosyal ve ekonomik nedenler, medyanın ve büyük firmaların destekleri gibi faktörler, modern tıbbın yapamadığını yapabileceğini iddia eden GTTU gibi, başka tedavi akımlarına güç kazandırmıştır (Goldstein, 2002; Mizrachi vd., 2005).

Bununla beraber, modern tıbbın yerine ikame iddiaları olan GTTU'da hemen her bağlamda bir meşruiyet sorunu yaşamış ve yaşamaktadır (Mizrachi vd., 2005). GTTU'nın yaşadığı meşruiyet sorunlarının temelinde kavramların tanımlarındaki bulanıklığın olduğu söylenebilir.

DSÖ, 2014 yılında yayımladığı son GTT stratejik planı ile Geleneksel ve Tamamlayıcı tıp kavramlarını birbirinden ayırmıştır. Buna göre, geleneksel tıp uygulamaları uzun bir tarihi geçmişe sahip, farklı kültürlerin sahip olduğu inanç, teori ve tecrübelere dayalı, açıklanabilen ve açıklanamayan, tedavi uygulamalarını içerir. Tamamlayıcı tıp uygulamaları ise, ülkelerin geleneğinde ya da hâlihazırdaki tıp sisteminde yer alamayan uygulamaları kapsar.

Tanımlardaki farklılıklar daha en başta GTTU'nın meşruiyetinin ölçümü konusunda bir sıkıntı doğurmaktadır. Örneğin, geleneksel uygulamalar için kullanılan bir ifade olan 'açıklanabilen veya açıklanamayan' ibaresi tamamlayıcı uygulamalar için kullanılmamıştır. Dolayısıyla modern tıp uygulamaları ile GTTU arasındaki, temel fark ölçüm ve değerlendirme ile gelmektedir. Bununla beraber iki tıp yaklaşımı arasındaki hastaya ve hastalığa yaklaşım, seçilen tedavi metodu ve tedavinin bilgi kaynağı gibi felsefik ayrışmalar ve farklılıklar da dikkat çekmektedir.

Örneğin, pek çok GTTU'nda hastalık vücuttaki bazı sıvıların dengelerinin bozulmasından kaynaklanır. Eğer doğru biçimde dengelenebilirse insan vücudunun kendi kendini tedavi edebilme özelliği GTTU'larında ön plana çıkar (Carroll, 2007; Sutton, 2010). Öte yandan bu genel kabulün tüm GTTU için geçerli olmadığı ve özellikle bazı tamamlayıcı uygulamalarda (örneğin proloterapi ya da ozon terapi) dışarıdan verilen maddeler ile vücuda müdahele edildiği de bir gerçektedir (Appendix D de uygulama tanımları görülebilir). Bu bağlamda GTTU için var olan bir meşruiyet tartışması, aslında hangi uygulama için hangi meşruiyet kriterinin baz alınacağı etrafında dönmektedir.

Bu bağlamda, GTTU'nın meşruiyeti için farklı kriter alternatifleri öne sürülmüştür. Bunlardan en bilineni, kanıta dayalı tıp yaklaşımı, herhangi bir tedavi metodunun teorik ve pratik altyapısının bilimsel kanıt ile desteklenmesi gerektiğini savunur (Willis & White, 2005). Bu yaklaşıma göre, bilimsel kanıtlarında bir hiyerarşisi vardır (Appendix B de görülebilir) (Willis & White, 2005). GTTU dâhil tedavi metotları bu hiyerarşi içinde yapılmış uygun bir çalışma ile desteklenebilir.

Kanıta dayalı tıp yaklaşımı GTTU'nın meşruiyet tartışmasında farklı açılardan eleştirilir. Örneğin bazı çalışmalar modern tedavilerin kanıt düzeylerinin de düşük olduğunu (Jackson & Scambler, 2007), bazı çalışmalar ise akupunktur ya da homeopati gibi bazı GTTU'nın doğaları gereği kanıta dayandırılmalarının zor olduğunu öne sürer (Cant & Sharma, 1996).

GTTU'nın meşruiyeti için yazında kabul edilmiş diğer bazı kriterler şöyle sıralanabilir: politik ve yasal meşruiyet, eğitim sistemlerinin içinde yer almak, sosyal sigorta sistemleri tarafından ödeniyor olmak (Willis & White, 2005), klinik olarak güvenli olduğunun hastalarda gözlenmiş olması, mali açıdan verimlilik sağlıyor olması gibi (Spencer, 2003).

Dolayısıyla GTTU'nın sağlık sistemlerine eklenmesinin önündeki en büyük etken bu uygulamaları değerlendirmede yaşanan sıkıntı gibi görünmektedir. Bu aynı zamanda profesyoneller arasındaki meşruiyet tartışmasının zeminini de oluşturur. Yazında GTTU'nın değerlendirilesi için farklı meşruiyet kriterleri öne sürülmüştür (Cant & Sharma, 1996; Jackson & Scambler, 2007; Spencer, 2003; Willis & White, 2005). Küresel bazı otoriteler de GTTU'nın sağlık sistemlerine eklenmesi konusunda yol gösterici bazı rapor ve planlar yayımlamışlardır. Benim çalışmam için bu raporların önemi, bazılarının içerdiği meşruiyet değerlendirmeleri ile alakalıdır.

DSÖ, ilki 1978 yılında, sonuncusu da 2014 yılında yayımlanmış olan 16 farklı rapor ile GTTU'nın üye ülkeler tarafından sağlık sistemlerine eklenmesini teşvik etmektedir. Bu raporlarda, kalite standartları, eğitim sistemleri, araştırma desenleri için öneriler ve üye ülkelerdeki GTTU'nın yasal statüleri gibi bilgiler yer almaktadır. Özellikle önerilen araştırma desenlerinde randomize çalışmalardan gerçek hayat gözlemlerine ve farklı yöntemlere doğru evrilen bir kabul gözlemlenmektedir (WHO, 2014). Bu da GTTU'nın meşruiyeti için esnek değerlendirme ve araştırmaların da kıymetli olduğunu gösterebilir.

Kayda değer diğer bir rapor serisi de bir Avrupa araştırma ağı olan Cambrella raporlarıdır. Cambrella raporları Avrupa ülkelerinde GTTU'nın kullanım sıklığı, yayılımı, eğitim bilgileri, yasal düzenlemeler gibi bilgileri içerir (Reiter vd., 2012). Bu raporların verdiği standart olmayan dağılım ve yayılım bilgileri hem GTTU'nın meşruiyet soruna işaret eder, hem de standartlaşmanın zor olduğunu belirtir.

Son olarak Unesco tarafından 2013 yılında yayımlanan raporda, farklı ülkeler GTTU'nın sağlık sistemlerindeki durumlarına göre, entegre ve yasaklanmış ikileminde sınıflandırılmıştır. Bu iki uç arasında, GTTU'nı tam eklemlemeyip sistemde yer veren ya da yasal düzenleme yapmayıp tolere eden ülkelerde mevcuttur.

Görüldüğü gibi, GTTU'nın değerlendirilmesinde pek çok farklı yaklaşım ve bunların sunduğu farklı meşruiyet kriterleri mevcuttur. GTTU uygulamalarının birbirlerinden farklı bir küme oluşturması, birden fazla meşruiyet kriterinin var olması ve bu kriterleri kullanarak değerlendirme yapan profesyonellerin farklı yaklaşımlarının ortaya çıkardığı bu çoğulluk durumu, meşrulaşmanın çok boyutlu bir süreç olarak kavramsallaştırılmasına imkan sağlayabilecektir.

Meşrulaşmanın çok boyutlu bir süreç olarak nasıl bir model sunacağı pek tabi bu boyutlar arasındaki etkileşime de bağlıdır. Bu anlamda, TSS'nin, GTTU ile ilgili yaşadığı süreç, kavramsallaştırmada uygun görgül zemini sağlayabileceğinden çalışmamın görgül bağlamı olarak seçilmiştir. Bir sonraki bölümde TSS'nin genel olarak nasıl evrildiği ve GTTU ile ilgili nasıl bir süreç geçirdiği özetlenecektir.

Türk Sağlık Sistemi ve GTTU

Türk Sağlık Sistemi'nin bir örgütsel alan olarak doğuşunu 1920'de ilk kez Sağlık Bakanlığı'nın kurulması ile başlatmak mümkündür. Öte yandan, alanın yaşadığı evrimin

sağlık sistemindeki herhangi bir değişimi etkileyebilecek olması ve bazı GTTU'nın geçmişten beri yaygın bir biçimde kullanılıyor olması nedenleriyle, GTTU'nın da TSS'inde yaşadığı süreci anlamak, önce TSS'nin Osmanlıdan başlayarak yaşadığı önemli gelişmeleri özetlemeyi gerektirir.

Osmanlı Dönemi ve Cumhuriyet döneminde TSS'nin evrimi

Osmanlı döneminde sağlık alanında başvurulan ve tedavi metotlarına temel olan başlıca kaynaklar Humoral Patoloji teorisi, halk tıbbı ve Tıbbı Nebevi denilen ve dini kaynaklardan beslenen peygamber tıbbı olarak özetlenebilir (Baran, 2013; Gadelrab, 2013).

15. ve 16. Yüzyıla kadar Osmanlı'da tıp alanında radikal bir anlayış değişikliği yaşanmamıştır. Günümüzde de bilinen müzik terapisi, sülük ve hacamat (Uygulama tanımları Apendix D de görülebilir) gibi bazı GTTU, Osmanlı döneminde de yaygın bir biçimde kullanılan uygulamalar olarak kaydedilir (Baran, 2013). Örneğin bazı kaynaklar, Osmanlı döneminde dahi Anadolu ve Balkanlarda bir tıbbi sülük piyasasının bulunduğundan ve bunları uygulamanın meşru bir tedavi olarak görüldüğünden bahseder (Baran, 2013). Öte yandan bu uygulamaların doktor olmayanlar tarafından yapılmasının dönem dönem yasaklandığından (Baran, 2013) ve insanları tedavi etme yetkisinin daha çok usta çırak eğitimi almış doktorlar tarafından yapılmasının devlet eliyle kontrol edildiğinden (Altıntaş & Doğan, 2004) bahseden kaynaklar mevcuttur.

17. yüzyılda, hemen her alanda olduğu gibi tıp alanında da modernleşme sürecinin başladığı görülür (Deniz, 2007; Salkı, 2008). 1827 yılında, Tıphane-i Amire adı altında modern tıp sistemi ile eğitim veren ilk tıp fakültesi kurulmuştur (Bayat, 2010; Deniz, 2007; Dole, 2004). Her ne kadar başlangıçta askeri tıp okulu olsa da, 1867 yılında sivil tıp fakültesi ile birleştirilen bu okul, batılı tarzda tıp eğitiminin temellerini atmıştır (Deniz, 2007; Dole, 2004).

Dolayısıyla 17. Yüzyıla kadar belirgin bir anlayış farklılığı yaşanmamış olan Osmanlı dönemi sağlık sisteminde, profesyoneller arasında GTTU'nın meşruiyetinin sorgulandığı yahut bu konuda bir meşruiyet tartışmasının yaşandığı pek görülmemiştir.

Cumhuriyet dönemi ile TSS, ülkenin topyekûn modernizasyonun bir parçası, hatta bunun bir aracı olarak görülmüştür (Dole, 2004). Buna göre, yeni kurulan Cumhuriyetin, hayatını mistik, metafizik ve dini kabuller yerine, bilim ile dizayn eden vatandaşlar oluşturma

çabasının (Dole, 2004) bir sonucu olarak Cumhuriyet modernleşmesi ile sağlık sisteminin gelişimi, özellikle ilk yıllarda içi içe gitmiştir (İlikan, 2014). Cumhuriyetin ilk yıllarındaki bu çaba ve kabullerin, TSS'nin ve sağlık profesyonellerinin daha sonraki yıllarda yaşadığı süreci hep etkileyen bir damga oluşturduğu kabul edilebilir.

Cumhuriyetin ilk yıllarında devletin ana amaçları sağlık hizmetlerini ülke sathına yaymak ve savaş sonrası ortaya çıkan salgınlar ile uğraşmak şeklindeydi (Ekinci, 1980; Soyer, 2001). Bu dönemdeki sağlık anlayışının daha çok koruyucu hekimlik yönünde olduğu bazı yazarlarca kabul edilir (Ekinci, 1980; Soyer, 2001).

1928 yılında yayımlanan 1219 sayılı Tababet ve Şua 'batlarının Tarzı icrasına dair kanun ile Türkiye Cumhuriyeti Devleti sınırları içinde hasta tedavi yetme yetkisi, geçerli bir tıp fakültesi diplomasına sahip olma şartına bağlanmıştır. Sadece doktorların değil, eczacı, fizyoterapist, hemşire ve ebe gibi diğer sağlık profesyonellerinin de meşru yetki alanları hakkında düzenlemeler yapan bu kanun, TSS'nin örgütsel alan oluşunun diğer adımı olarak kabul edilebilir.

TSS'ni etkileyen diğer bir önemli olay ise 1933 Üniversite reformudur. Her ne kadar farklı fakülteleri bir araya toplayıp, Cumhuriyetin ilk üniversitesini oluşturma babında sadece tıp fakültesini ilgilendiren bir değişiklik olmasa da, pek çok çalışma, Türkiye'de tıp eğitiminin modern tıbba asıl yönelişinin başlangıcı olarak bu reformu kabul ederler (Bagatur, 2014; Ceylan, 2012; Erdem, 2012).

1960 yılında yayımlanan Tıbbi Deontoloji nizamnamesi doktorlara etik kurallar çerçevesinde istedikleri ve hastanın kabul ettiği herhangi bir tedavi yöntemini kullanma yetkisi veren, bu bağlamda alandaki profesyonel yetkinliğini belirleyen bir diğer önemli düzenlemedir.

2. Dünya savaşından sonra DSÖ ve Unicef gibi küresel örgütlerle olan ilişkilerin başlaması ile bazı yazarlara göre tıp alanında o güne kadar hâkim olan koruyucu hekimlik anlayışı yerini yavaş yavaş tedavi odaklı bir hekimliğe bırakmaya başlamıştır (Soyer, 2001). Yine bu durum, sağlık alanında piyasa mantığının belirlemeye başlaması ile ilintilendirilir (Soyer, 2001).

1980'den sonra kabul göremeye başlayan neoliberal politikalar sağlık alanında da etkisini göstermiştir (Kavas & İlhan, 2010). Buna bağlı olarak, tedavi odaklı sağlık anlayışında artış,

teşhiste laboratuvar testlerinin artması, özel hastanelerin kurulması ve sağlık alanında rekabet gibi kavramlar belirmeye başlamıştır (İzgi & Çoban, 2014).

Son olarak, 2003 yılında başlayan sağlıkta dönüşüm programı ile TSS'inde özelleşmenin arttığı, devletin sigorta ödeme sistemleri üzerine yoğunlaştığı bir dönem başlamıştır (Çavmak & Çavmak, 2017). Bununla birlikte bu program bazı çevrelerce sağlığın insan hakkı olmaktan çıkıp, satılabilir bir obje haline geldiği (İzgi & Arda, 2012) bir dönemi getirmiştir. Hatta bazı meslek örgütleri, bu programı sağlıkta muhafazakârlaşmanın bir adımı olarak görmektedir (Ankara Tabip Odası, 2017).

Bu noktaya kadar TSS'ni etkileyen bazı önemli olaylar sıralamıştır. Her ne kadar, bu gelişmelerin GTTU ile direk ilgisi olmasa da, GTTU'nın nasıl bir alana eklemlenmeye çalışıldığı konusunda bağlamsal bilgi vermektedir. Bu olaylar, alandaki hâkim meşruiyet kriterleri ve profesyonellerin durumları konusunda da bilgi vermektedir.

GTTU'nın TSS'ne girişi

Her ne kadar TSS'nde hukuki olarak düzenlenen ilk uygulama 1991'de düzenlenen akupunktur olsa da; TSS'nin geçirdiği süreçteki dört olay, GTTU'nın legal ve profesyonel süreci üzerinde etkin olabilir. Bunları, Cumhuriyetin ilk yıllarında sağlık sisteminin modernleşmenin bir aracı olarak görülmesinin bıraktığı politik ve ideolojik etki, 1219 sayılı tababet kanunu ve 1960 da yayımlanan tıbbi deontoloji düzenlemesi ve son olarak tıp eğitimi olarak özetleyebiliriz.

1219 sayılı yasa ve 1960 yılındaki düzenleme, doktorlara insan tedavi etme konusunda yasal bir meşruiyet sağlamakta, tedavi serbestisi ile profesyonel yetki alanlarını da geniş tutmaktadır. Öte yandan, tıp fakültesi eğitimi ve TSS'nin yaşadığı politik ve ideolojik süreçler etkileri daha zor ölçülebilen olaylar olarak görülebilir. Buna göre, tıp fakültelerinde öğretilen bilgiler modern tıp sistemi ile uyumludur. Ayrıca, modernizasyon sürecinin etkisi ile geleneksel ve eskiye ait olan hemen her şey (tedavi yöntemleri dâhil) sistem dışı tutulmaya çalışılmıştır (Dole, 2004). Böylece GTTU ve onlara ait bilgi sağlık alanı dışındaki bazı insanlar tarafından, çoğunlukla denetimsiz olarak, taşınır ve uygulanır olmuştur (Mollahaliloğlu, Uğurlu, Kalaycı, & Öztaş, 2015; Şimşek vd., 2017). Ayrıca bu durum, bazı GTTU'nın doktorlar tarafından yok sayılmasına ve bayağı görülmesine neden olmuştur (Mollahaliloğlu vd., 2015; Şimşek vd., 2017).

Tüm bunlara rağmen, 2014 yılında yapılan bir düzenleme ile 15 farklı GTTU'sına doktorlar ve sağlık profesyonelleri tarafından uygulanması şartı ile yasal meşruiyet sağlanmıştır. Daha önce akupunktur ile ilgili yapılan düzenlemeler, 1980 den itibaren farklı zamanlarda bitkisel tedaviler ve fitoterapi (Uygulama açıklaması Appendix D de görülebilir) ile ilgili yapılan düzenlemeler ve 2012 yılında başlayan yönetmelik hazırlık süreçleri, 2014 yılındaki GTTU yönetmeliğinin yasal alt yapısına imkân sağlamıştır.

Sağlık Bakanlığı tarafından, belirli bir skorlama tekniğine (Döker, 2014) göre elenen ve seçilen 15 uygulama için yasal meşruiyet sağlanmıştır. Bu skorlama skalasında uygulamanın Cochrane and PubMed yayınları, Türkiye'de ve diğer ülkelerdeki yaygınlığı, eğitim sisteminde yer alıp almadığı gibi kıstaslar bulunmaktadır. Bu kıstasların TSS'de düzenlenen GTTU için meşruiyet kriterleri olabileceği düşünülürse hem birden fazla meşruiyet kriterinin var olduğu bir bağlamla, hem de bu kriterlere göre farklı seviyelerde yer alan uygulamalarla karşı karşıya kalındığı belirtilmiştir (Mollahaliloğlu vd., 2015).

İşte bu noktada TSS'de en yetkin aktör olan doktorların ve diğer sağlık profesyonellerinin, GTTU'nın meşruiyeti konusunda bir tartışmaya girdiği görülür. Buna göre, TSS'nde hâkim anlayışın dışında bazı uygulamaların yer almaması gerektiğini savunanlar, GTTU düzenlemesini yerinde bulup, tek başına bir veya birden fazla uygulamanın meşruiyetini sorgulayanlar, durumu yok sayanlar ya da düzenleme öncesinde GTTU alanına ilgisi olmayıp, sonrasında sertifika alarak uygulamaya başlayanlar gibi pek çok profesyonel tepkisinin var olduğu söylenebilir.

Düzenlenen GTTU'nın hangisinin tamamlayıcı hangisinin geleneksel olduğunun açık olmaması (Karahancı vd., 2015), uygulamalarının hepsinin Türkiye bağlamına kültürel anlamda ait olmaması, bazı uygulamaların daha 'bilimsel' olduğunun kabul edilmesi gibi konularda profesyonellerin bir meşruiyet tartışmasına girdiği görülmüştür. Türk Tabipleri Birliği tarafından yönetmeliğin iptali için dava açılmıştır.

Her ne kadar, profesyoneller arasında böylesi bir bölünme ve meşruiyet tartışması yaşanıyor olsa dahi, bir yandan da TSS'nde GTTU'nın hızla yayıldığı gözlemlenmektedir. Buna göre, kayropraktik hariç tüm uygulamaları için eğitim standartları belirlenmiştir. Haziran 2018 itibariyle, 15 farklı eğitim merkezinde kayropraktik hariç tüm uygulamaların eğitimleri başlamıştır. Toplam 38 üniversite hastanesi ve kamu hastanesi uygulama merkezi ve ünite olarak farklı GTTU için yetki almıştır. Buna göre, en fazla eğitimi verilen ve uygulama

yetkisi alınan uygulamalar akupunktur, kupa terapisi ve sülük terapisidir. Ayrıca GTTU'nın kullanım sıklığını ve hangi uygulamaların en çok tercih edildiğini araştıran (Şimşek vd., 2017) ya da sağlık profesyonellerinin GTTU hakkındaki bilgisini, yaklaşımlarını ve hastaların kullanımları konularındaki bilgilerini belirleyen çalışmalar yapılmaktadır (Özkaptan & Kapucu, 2014; Uzun & Tan, 2004).

Araştırma bağlamının sunduğu olanaklar

TSS'nin GTTU hakkında yaşadığı süreç, başlangıçta önerdiğim meşruiyeti çok boyutlu bir süreç olarak çalışma ve olası bir modeli yakalama kavramsal fırsatını araştırmak için uygun görgül ortamı sağlıyor görünmektedir.

Buna göre, düzenlenen uygulamalar arasındaki farklar nedeniyle uygulamaların yazında çalışılandan farklı olarak heterojen bir küme olması, meşruiyet değerlendirmesi yapanların kullandığı meşruiyet kriterlerin çokluğu, bunların ve profesyonellerin bu kriterleri nasıl bir araya getirdikleri süreci açıklayıcı olabilecektir. En önemlisi is TSS bu üç boyut arasındaki etkileşim için uygun görgül malzemeyi sağlayabilir.

Özetin bir sonraki bölümünde, bu kavramsal fırsatı araştırmak için nasıl bir yöntem kullandığım, nasıl bir analiz ile bulgulara ulaştığım açıklanacaktır.

Yöntem

Yaklaşık üç yıl süren bu çalışma, GTTU'nın TSS'ne eklenmesi sürecinde oluşan meşruiyet tartışmasını çok boyutlu bir şekilde modellemek üzere, nitel bir araştırma olarak tasarlandı. Meşruiyet, profesyoneller ve sağlık alanı ile ilgili yazının bazı ön kabuller ile şekillendirdiği bir çalışma olarak ilerledi (Bitektine & Haack, 2015; Corley & Gioia, 2011; Currie & Spyridonidis, 2016; Gioia, Corley & Hamilton, 2013; Suddaby et al., 2017). Bu nedenle, araştırma yaklaşımı kuramın sadece veriden çıktığı bir gömülü teori (Glaser & Strauss, 1967) çalışması değil, ve fakat tamamen ilgili yazının şekillendirdiği bir içerik analizi de değildir**.**

Araştırma yöntemi daha önce pek çok yazar tarafından geliştirilen ve Saldaña (2009) ve Miles, Huberman ve Saldaña (2014) tarafından analiz yöntemi olarak kabul edilen bazı kodlama yöntemleri ve soyutlama esasına dayalı, her bir adımda ilgili yazın ve veri arasında tekrarlamalar ile (Glaser & Strauss, 1967), kuramsal doygunluğa ulaşma esasına dayalıdır.

Nisan 2015 te bazı keşifsel mülakatlar ile başlayan veri toplama süreci, Mart 2018 de tüm verinin analizinin tamamlanması ile sonuçlanmıştır. Araştırmanın ana veri setini oluşturan mülakat verisi ve diğer verilerin toplanması iki etapta tamamlanmıştır. İlk 25 mülakat Kasım 2015- Mart 2016 tarihleri arasında toplanmıştır. İkinci etaptaki 27 mülakat, 3 alan gözlemine ait veri ve diğer kaynaklara ait veriler ise Ekim 2017-Aralık 2017 tarihleri arasında toplanmıştır. İki etaplı veri toplama, hem nitel araştırma doğası gereği veri ile yazın arasındaki tekrarlamalardan (Glaser & Strauss, 1967), hem de alanın yaşadığı ekstra gelişmelerden kaynaklanmıştır.

Araştırmanın etik izni Ankara Yıldırım Beyazıt Üniversitesi etik kurulundan alınmıştır. Mülakat katılımcılarından aydınlatılmış onam formu kendi imzaları ile alınmış, izin veren katılımcılardan ses kaydı alınmıştır. Tüm katılımcılar araştırmanın amacı hakkında bilgilendirilmiş, istedikleri zaman görüşmeyi sonlandırabilecekleri bilgisi verilmiştir.

Örneklem

Çalışmanın ilk aşamasında amacım sağlık alanında meydana gelen bir değişiklik konusunda keşifsel veri toplamaktı. Dolayısıyla ilk etap mülakat örneklemi sadece sağlık profesyonellerini değil, GTTU'ndan bazılarını tecrübe etmiş insanları ve doktor olmayan uygulayıcıları da içermekteydi. İlk katılımcıları, GTTU'nı icra eden doktorlarla onlara muhalif olanlardan seçtim. Ayrıca Sağlık Bakanlığı görevlileri ile düzenlemenin iptali için dava açan meslek örgütü yetkilileri ile de ilk etap mülakatlarda görüştüm.

İkinci etap mülakatlarda ise, ilk etapta toplanan ve yapısal kodlama (Saldaña, 2009) ile kısmi analizi yapılan veri seti, örneklem kararında etkili oldu. Buna göre, ikinci etaptaki katılımcılar, daha sistematik veri sağlayacak olan ve meşruiyet yazını ile profesyoneller yazınını birlikte çalışma imkânı verecek veriyi sunabilecek sağlık profesyonellerinden seçildi.

Mülakat verisinin toplanma süreci kodlama ile eş zamanlı yapıldığından, teorik doygunluğa (Strauss & Corbin, 1998) yani katılımcılardan yeni bir kategorinin gelmediği aşamaya kadar mülakat yapmaya devam edildi. Buna göre analizi yapılan son mülakat verisi toplam 47 sağlık personelinden toplanmış olundu. Bunlardan 41 tanesi farklı uzmanlık alanlarında ya da pratisyen olan tıp doktorları, 1 tanesi fizyoterapist, 3 tanesi eczacı ve 2 tanesi de diş hekimidir. Yapılan diğer 5 mülakat sağlık profesyonelleri ile yapılmadığından nihai analizin dışında bırakıldı.

Mülakatlar

Genellikle katılımcıların çalıştıkları kliniklerde, eğitim mekânlarında ya da hastanelerde yapılan yarı yapılandırılmış mülakatlar 17 ile 89 dakika arası sürdü. Katılımcılardan üçü ses kaydının alınmasına izin vermediği için diğer katılımcıların mülakatları kaydedildi ve çözümü yapıldı. Ses kaydı alınmayan mülakatlarda notlar alındı. Mülakat verisini toplamda 40 saatlik bir ses kaydının çözümü yapılmış 747 sayfalık verisi oluşturmuştur.

Her bir mülakat aynı zamanda alan gözlemi fırsatı olarak görülmüş ve öncesinde ve sonrasında memo notları alınmıştır (Saldaña, 2009)

Alan Gözlemleri ve diğer veri kaynakları

Alan gözlemlerine ve diğer veri kaynaklarından elde edilen verilere yaklaşımım, mülakat verisini doğrulamak (ya da yanlışlamak) üzere analiz etme ve bağlamın tarihi ve arka planı hakkında bilgi sağlayıcı araç olarak kullanma şeklinde olmuştur.

Buna göre, üç ayrı GTTU merkezini ziyaret ederek alan gözlemi yaptım. Bunlardan bir tanesi ünite diğer ikisi ise uygulama merkezi idi. Yaklaşık 4-5 saat geçirdiğim mekânlarda uygulayıcı doktorlar ile görüşme, uygulama gözlemleme ve hastalar ile tecrübeleri konusunda görüşme imkanı buldum.

Diğer veri kaynaklarını ise, ulaşabildiğim dergiler, arşiv dokümanları, çeşitli basın bildirileri, yayımlanan makale ve kitaplar oluşturdu. Küresel ve yerel olarak yayımlanmış bazı raporlar, kalkınma planları, Türkiye Büyük Millet Meclisi tutanakları da tarandı. Buna göre meslek örgütlerinin ve bazı üniversitelerin yayınladığı 6 tane dergide ve 4 farklı raporda sistematik tarama yapıldı. Bunun dışında yayımlanmış olan farklı kitap ve makalelerde incelendi.

Veri Analizi

Araştırmanın analizini genel olarak veri ile kuramın, verinin ve kuramın kendi içlerinde sürekli olarak karşılaştırıldığı (Strauss & Corbin 1990) ve birden fazla kodlama tekniğinin ana analiz yöntemi olduğu (Miles, vd., 2014) bir süreç olarak tanımlayabilirim. Buna göre, analiz ilk olarak mülakat verisinin ön kodlanması (Saldaña, 2009) ile başlamıştır. Kod sözel verideki özü temsil eden ifade ya da cümle öbekcikleri olarak tanımlanabilir. Kodların onları benzerliklerine ya da farklarına göre kümeleyen kategorilere evrildiği bir analiz süreci

izlenmiştir. Çıkan sonuçlar, sürekli olarak yazın bilgisi, alan bilgisi ve diğer veri setleri ile denetlenmiştir.

Her bir veri toplama etabını kendi içinde yaşadığı analiz süreci ile alakalı şu şekilde özetleyebilirim. İlk etapta yapılan 25 mülakat öncelikle yapısal kodlama ile kodlandı. Ardından benzerlik ve farklılıklarına göre eksen kodlaması yapıldı (Saldaña, 2009). Bu ilk etap analizde, her ne kadar bağlam hakkında bilgi gelsede, soyutlamadan uzak bulgularla karşılaştım. Bu noktada yazına da başvurarak ikinci etap veri toplama sürecine başladım.

Buna göre, ilk analizler bana TSS'ndeki sağlık profesyonellerinin GTTU ile direkt ilgilisi olmayan bir bölünme içinde olduklarına dair ipuçları vermişti. Ayrıca, katılımcıların meşruiyet kriterlerinin çokluğu bunları nasıl bir araya getirdikleri konusunda kısmi bilgi veriyordu. Bunlara benzer nedenlerle araştırmanın ikinci kısmında sadece sağlık profesyonelleri ile yeniden mülakat yaptım. Araştırmanın bu aşamasında başlangıçta daha keşifsel olan araştırma sorusu da değişmiş oldu.

İkinci etap veri toplama süreci bittiğinde, tüm datayı yeniden analiz yaptım. Bu analiz toplam 3 aşamadan oluştu.

Birinci aşamada, katılımcıların herhangi bir tıbbi uygulamanın meşruiyetini değerlendirmek için hangi kriterleri kullandıklarını ortaya çıkarmak üzere, ön kodlama yöntemi ile değerlendirme, uygunluk, onay verme ya da bunların tam tersini belirten ifadelerini kodladım. Akabinde bu kodlar, benzerlik ve farklılıklarına göre eksen kodlaması yapılarak kategorilere ayrıldı. En son yapılan teorik kodlama ile katılımcıların kullandığı 12 temel meşruiyet kriterine ulaşıldı. Buna göre analizin ilk aşamasında 47 sağlık profesyonelinin verisini önce her mülakatı kendi içinde olacak şekilde ön kodlama ile kodlandı. Ardından, kodlar arasındaki benzerlikler ve farklılıkları eksen kodlaması yaparak belirledim. Eksen kodlaması sonrasında birbiri ile alakalı olan kodları gruplayarak her bir mülakatın nihai birinci derecen kodlarını belirledim. Örneğin, 4 numaralı mülakatın açık kodlama sonucu 64 tane kodu vardı. Bunların içinde, 'fiyatlama'; 'kontrolsüz satış'; 'piyasada dönen kontrol dışı para' gibi ifadeler adını 'ticari boyut' olarak belirlediğim kod etrafında toplanmış oldu. Bu tür kodlama bana mülakatlar arası karşılaştırma imkanını açtı. Mesela 12. mülakat için ticari boyut kodu 'uygun maliyetli düşünme'; 'sağlık giderlerini azaltma' gibi ifadeleri içeriyordu. Ancak meşruiyet kriterlerimi belirlemek için bu kategoriler arasından da teorik kodlama ile

değerlendirme ifadesi içerenler ayıklandı. Sonuç olarak 12 temel meşruiyet kriteri belirlenmiş oldu.

Analizin ikinci aşamasında düzenlenen GTTU uygulamalarının özelliklerini belirleyebilmek için nitelik kodlaması yaptım. Bu aşamada katılımcıların mülakat çözümlerinde ve diğer veri kaynaklarında bulunan, herhangi bir GTTU'sını betimleyici ifadelerinden yola çıkarak bazı boyutlara ulaştım. Buna göre, düzenlenen GTTU'nın niteliklerini beş farklı boyutta inceledim. Bu boyutların ne olabileceğine dair bilgi hem ilgili yazından (Bicho et al., 2013; Broom & Tovey, 2007) hem de bağlamdan gelmiş oldu. Sonuç olarak, düzenlenen GTTU'ların nitelikleri beş temel boyutta kodlanmış olundu. Bunlar; Geleneksel mi/ Tamamlayıcı mı; İlaç ve benzeri madde ilhakı içeriyor mu; bilgisinin dayandığı bir felsefesi var mı; tarihi geçmişi var mı ve dini metinlerde geçiyor mu olarak belirlendi.

Analizin üçüncü aşamasında ise, meşruiyet değerlendirmesi yapan katılımcı profesyonellere nitelik kodlaması yaptım. Buradan da profesyonellerin kendilerini veya diğer meslektaşlarını nasıl betimlediklerine dair bazı analitik kategorilere ulaştım. Bu aşamada belirlenen analitik kategoriler, meşrulaşma sürecinde profesyonellerin, meşruiyet kriterleri ve düzenlenen GTTU'lar ile nasıl etkileşimde olduklarına dair teorik çıkarımlara dayanak oluşturan görgül bulguyu sunmuş oldu.

Çalışmanın diğer verilerini oluşturan kaynakların analizi de, her bir kaynağın kendi sunduğu imkânlara göre belirlenmiş kodların ve kategorilerin denetlenmesine yönelik olarak yapıldı.

Bulgular

Araştırmanın başında bir meşrulaşmanın meşrulaştırılan uygulamalar, meşruiyet kriterleri ve profesyonellerin etkileşimi ile daha güvenilir biçimde açıklanabilecek çok boyutlu bir süreç olduğunu önermiştim. Çalışma sonuçlarına göre, meşrulaştırılan GTTU, yazından genellikle çalışılandan farklı olarak birbirinden oldukça farklı, bazısı sağlık alanının geçmişte dışında bırakılmış uygulamalardan oluşuyor. Yine sonuçlara göre çok çeşitli meşruiyet kriterleri değerlendirenler tarafından kullanılıyor. Bu iki boyutun en belirgin etkileşimi GTTU uygulamalarından bazıları için geçerli ve kullanılabilen bir meşruiyet kriteri bir diğeri için anlamsız ya da kullanılamaz olabiliyor. Son olarak, TSS'ndeki profesyoneller arasındaki bazı bölünmeler her ne kadar meşruiyet süreci ile direk ilgili olmasa da süreci belirleyen bir unsur olarak ortaya çıkıyor.

Araştırmanın iki temel bulgusu, meşrulaşma sürecinin uygulamalar, kriterler ve profesyonellerin belirlediği çok boyutlu bir süreç olması ve bu boyutlar arasındaki sürekli etkileşimin meşrulaşmayı her daim, sorgulanabilir ve problemli kılması olarak özetlenebilir.

Araştırma sonuçlarına göre, profesyonellerin herhangi bir uygulamayı tıbbi uygulama olarak kabul etmeleri için (GTTU olsun ya da olmasın) 12 tane temel meşruiyet kriterini sağlaması ya da bunlarla uyumlu olması bekleniyor. Bu kriterler, zararlı olmama, etkin olma, güvenli ve geçerli olma, bir tıp doktorunun tercihine dayanma, devlet tarafından ya da DSÖ tarafından tanınmış ve kabul edilmiş olma, milli olma, Peygamber tarafından uygulanmış olma, temel bir felsefeye sahip olma, ekonomik olarak değerli olma ve devlet bütçesi için anlam ifade etme şeklinde belirmiştir. Örneklendirmek gerekirse, bazı katılımcılar için devletin herhangi bir uygulama için yönetmelik çıkartması o uygulamanın meşru olması anlamına gelirken (Katılımcı # 36 gibi), bazıları için DSÖ tarafından tanınmış olsa bile meşruiyeti sorgulanabilir (Katılımcı #13 gibi).

Bulgulara göre bu 12 meşruiyet kriterinin hepsi bütün katılımcılar tarafından kullanılmamıştır. Ayrıca hepsi meşrulaştırmak için değil bazıları da meşruiyeti sorgulamak için harekete geçirilmiştir. Yine katılımcıların hepsinin bütün uygulamalar hakkında konuşmadıklarını düşünürsek, 12 kriterin hepsi her uygulama için birebir sistematik olarak kullanıldı diyemeyiz.

Meşrulaşmanın diğer boyutu olarak ele alınan uygulamalarla ilgili olarak ise, belirlenen beş boyuta göre, yönetmelikle düzenlenen 15 GTTU'sına nitelik kodlaması yapılmıştı. Buna göre bu uygumaların geleneksel mi yoksa tamamlayıcı mı olduğu, herhangi bir ilaç ya da medical karışım ilhakı içerip içermediği, herhangi bir felsefeye dayanıp dayanmadığı, tarihi belgelerde yer alacak kadar eski bir tarihinin olup olmadığı (burada son 100 yıl öncesi baz alındı) ve dini metinlerde yer alıp almadığına göre birbirlerinden farklılık gösterdiği tespit edildi.

Son olarak, TSS'ndeki profesyoneller arasında, GTTU'nın düzenlenmesinden bağımsız olan bir mesleki bölünmenin var olduğu verilerden ortaya çıkmıştır. Bu bölünme, meşrulaşma sürecinin sebebi ya da sonucu olmayıp, meşrulaşma sürecini belirleyen bir unsur olması sebebiyle çalışma için önemlidir. Yapılan nitelik kodlamasına göre, profesyoneller 3 analitik gruba ayrışmaktadır. Bunlar, (1) Bütüncül yaklaşımda olma ya da materyalist olma; (2)

Piyasa odaklı olma ya da olmama ve (3) Toplumcu/Milliyetçi/Dindar yada Ilımlı olma şeklinde belirmiştir.

Buna göre birinci analitik grup, profesyonellerin tıbba genel bakışı ile alakalıdır. Bazı profesyoneller kendilerini veya diğer meslektaşlarını bütüncül bakış açısına sahip olma ya da bütüncül değil parçacı ve metaryalist bakanlar olarak tanımlamışlardır. İkinci analitik grupta profesyoneller sağlık hizmetinin sunumundan para kazanmaya bakışlarına göre bunu hoş ya da görmeyenler olarak ayrıştırılmıştır. Para kazanmanın doğal hatta gerekli olduğunu savunan profesyoneller olduğu gibi, kesinlikle red edenler de vardır. Son olarak, profesyoneller kendilerini ya da meslektaşlarını politik ve ideolojik tercihlerine göre dört farklı şekilde tanımlamışlardır. Bu ayrımda bazı profesyonellerin, sağlık alanı ile direk ilgili olmasa da kendilerini ideolojik olarak tanımladıkları, diğer bazılarının ise bu tarz ayrımlara hiç girmeden konuştukları gözlemlenmiştir.

Görgül bulgular, TSS'nde meşrulaşma sürecinin konusu olan uygulamaların heterejonliğini, kullanılan meşruiyet kriterlerinin çokluğunu ve profesyoneller arasında sürece nüfus eden bir bölünmenin var olduğu görülmüştür. Ancak meşrulaşmayı çok boyutlu bir model olarak tanımlayan aslında bu görgül bulgulardan ziyade bunların birbirleri ile olan etkileşimidir. Buna göre, her ne kadar sonuçları paternize etmek zor olsa da, meşrulaşma sürecine hakim olan iki mesleki profil ortaya çıkmaktadır.

Hakim mesleki profillerden ilki, toplumcu/piyasa odaklı olmayan ve materyalist olan profesyonellerdir. Bu profildeki profesyonellerin genel olarak GTTU'nın TSS'ne girişini meşrulaştırmama amacında oldukları gözlemlenmiştir. Yine bu profildekiler ağırlıklı olarak, uygulamaların zararlı olabildiği durumları, uygun araştırma yöntemi ile yapılmamış GTTU çalışmalarını ve daha çok kupa terapisi ve sülük uygulaması gibi geleneksel uygulamaları söylemlerinde ön plana çıkarmaktadırlar. Tamamlayıcı uygulamalar için pahalı olma gibi daha pragmatik ifadeler söylemlerinde yer almaktadır.

Diğer bir hakim mesleki profil ise, bütüncül/ piyasa odaklı olan ancak herhangi bir ideoloji ile kendisini tanımlamayıp daha ılımlı olanlardan oluşmaktadır. Bu grubun temel amacı GTTU'nı meşrulaştırmak olarak görünmektedir. Bunun için daha çok etkinliği görece daha kanıtlanmış ola akupunktur gibi uygulamaları söylemlerin ön plana çıkardıkları görülür. Bununla beraber DSÖ'nün onayını ve uygulamaların felsefesini kriter olarak ön plana

çıkardıkları ve bazı kriterlerden (Peygamber uygulaması olması gibi) kaçındıkları görülmüştür.

Her ne kadar iki hakim profil meşrulaşma sürecini hareketlendiriyor görünse de arada olan bazı istisnai profillerde vardır. Örneğin toplumcu ve materyalist olup bazı şartlar altında bazı GTTU'larını tolere eden katılımcı # 17 ve 52 gibi.

Buraya kadar anlatılan bulgularda örneklendiği gibi, ortaya çıkan profesyonel profilleri uygulamalar, meşruiyet kriterleri ve değerlendirenler arasındaki etkileşim ile meşrulaşma sürecini açıklayan çok boyutlu bir model olarak ortaya koymaktadır.

Tartışma

Araştırmanın başında meşrulaşmanın çok boyutlu bir süreç olarak ele alınmasının yazında genel olarak çalışıldığı hali ile tek boyutlu çalışmanın neden olduğu bazı riskleri berteraf edeceğini önermiştim. Yine meşrulaşma sürecini, meşrulaştırılan uygulamalar, meşruiyet kriterleri ve meşruiyet değerlendirmesi yapan profesyoneller arasındaki etkileşim ile evrilen bir süreç olabileceğini önermiştim.

Araştırma bulguları, meşruiyet kriterlerinin çokluğu konusunda yazınla uyumlu sonuçlar verdi. Yazında da genel olarak çeşitli kriterlerin bir arada olabileceği (Fisher vd., 2017; Laïfi & Josserand, 2016) ve bunun meşrulaşma sürecini nasıl yönlendireceği araştırılmıştır. Ancak bu kriterlerin genellikle değerlendirilenler ile olan etkileşimi incelenmiştir. Çünkü meşrulaştırma öznesi olarak ele alınan, yazında çoğunlukla tek bir uygulamadır.

Ancak bu araştırmanın bulguları meşrulaştırılan uygulamaların birbirinden çok farklı ve bu nedenle de farklı meşruiyet kriterleri ile değerlendirilmesi gereken bir küme olabileceğini ortaya koymuştur. Bunun dışında yine uygulamalar ile ilgili olan bulgulara göre küme içindeki bazılarının, alana yeni olmayıp, bir şekilde alan dışında kalmış uygulamalar olması da yine farklı meşruiyet kriterleri ile etkileşim noktası olarak ortaya çıkmıştır.

Meşrulaşmanın bir boyutu olarak profesyoneller ise, yazında genel kabul edilenin aksine (Ruef & Scott, 1998) sadece normatif meşruiyet ile değerlendirme yapmayan değerlendiriciler olarak belirmiştir. Aslında herhangi bir değişimin profesyoneller arasında bölünmeye neden olduğu yazının da kabul ettiği bir durumdur (Currie & Spyridonidis, 2016; Suddaby & Viale, 2011; Wry, Lounsbury & Glynn, 2011). Genellikle bu bölünmeler alan içi statü ve güç gibi dinamikler ile açıklanmıştır. Bu çalışmada ise profesyonellerin alandaki

pozisyon ya da statülerinin herhangi bir belirleyiciliği saptanmamıştır. Ayrıca gözlemlenen, meşruiyet tartışmasının yarattığı bir bölünme değil; var olan bir bölünmenin meşruiyet tartışmasını şekillendirmesidir.

Sonuçta ortaya çıkan iki temel mesleki profil şu andaki meşrulaşma sürecini yönlendiriyor görünmektedir. Öte yandan, şu anda hakim olmayan ve istisnai olarak gözlemlenen profillerin gelecekte süreci yönlendirmesi mümkün olabilir. Yahut, şu anda kullanılan bazı meşruiyet kriterlerinin ileride elimine olması veya yeni kriterlerin belirmesi olasıdır. Yine meşrulaştırılmaya çalışılan bir küme olduğuna göre, bu kümenin sabit kalması da beklenemez. Ayrıca belirlenen profiller Türkiye bağlamına özgü de olabilir. İşte tüm bu nedenlerle meşrulaşma süreci bir defada olup biten ve sonuçları sabit bir süreç olmayıp hangi bağlamda olursa olsun, çok boyutlu bir şekilde bu boyutlar arasındaki etkileşimler dikkate alınarak açıklanması gereken bir süreçtir. Ancak bu sayede, olası yanlılık ve kritik dinamiklerin göz ardı edilmesi riskleri bertaraf edilip, sürecin tamamı açıklanabilir bir model yakalanabilir. Deephouse vd., (2017)'nin belirlediği meşruiyet boyutlarını bu şekilde bir arada görgül bağlamda araştıran ve bir açıklayıcı modele ulaşan çalışma daha önce yapılmadığından yazına ana katkımız bu modelin geliştirilmiş olmasıdır.

Araştırma amacını taşıyan kuramsal önerilerle ilgili sonuçların dışında, araştırmanın bulguları bazı beklenmeyen sonuçları da ortaya çıkarmıştır. Örneğin meşruiyet kriterinin meşruiyeti gibi bir mesele ortaya çıkmıştır. Bazı katılımcılar için herhangi bir tedavi metodunun (GTTU dahil) meşru olabilmesi için ekonomik değer (Katılımcılar # 16 ve 17 gibi) ya da peygamberin uygulaması (Katılımcılar # 1 ve 23 gibi) meşru bir meşruiyet kriteri olamaz.

Diğer bir beklenmeyen netice ise ilgili yazında rasyonel aktör ve kabul edilmiş bir meşruiyet kaynağı olan devlet (Scott vd., 2000) ya da meslek örgütü (Greenwood, Suddaby & Hinings, 2002) gibi aktörlerin, TSS bağlamında yazında anlatıldığı şekilde meşru ve temsili görünmediği sonucu ortaya çıkmıştır.

Son olarak, GTTU'ları hakkındaki yazında genel olarak kabul edilen, sağlık sistemine eklemlenme nedeni olarak herhangi bir sosyal hareket TSS'nde gözlemlenmemiştir (Mizrachi vd., 2005; O'Callaghan & Jordan, 2003)

Özet bölümü, çalışmanın bazı kısıtları ve gelecek çalışma beklentilerinin anlatılması ile sonlandırılacaktır.

Sonuç

Kuramsal katkılarının yanı sıra çalışmanın TTS'ne yönelik bazı idari ve pratik önerileri ortaya çıkmıştır. Bununla beraber üç yıl süren ve tartışmalı bir meşrulaşma sürecini anlatan bu nitel çalışmanın, bazı kısıtları da bulunmaktadır. İlerleyen dönemlerde yeni çalışmalar için bazı kapıları araladığı da söylenebilir.

İdari ve Pratik bazı öneriler

Çalışmanın sonucunda düzenleyiciler için ilk idari önerim, GTTU mevzuat metni hakkında olacaktır. Metin GTTU uygulamalarını bir bütün, hepsi aynı niteliklere sahip bir paket gibi görmektedir. Oysaki çalışma boyunca GTTU arasında pek çok açıdan büyük farklar olduğu ve bu farkların profesyonellerin algıları ve tepkileri üzerinde etkili olduğu ortaya çıkmıştır. Öyleyse tartışmaları önleyecek ilk önlem, mevzuat metninde hangi uygulamanın geleneksel hangisinin tamamlayıcı olduğunun belirlenmesi olabilir.

Diğer bir konu ise yine TTS'nde bir ağız birliğinin oluşması için, düzenleyicilerin, meslek örgütlerinin ve profesyonellerin birlikte hareket etmesi ve bunun teşvik edilmesinin yararıdır.

Son olarak, GTTU'nın TSS'ne eklemlenmesi sağlık hizmetinin sunulmasında yeni bir yapılanmayı getirebilir. Farklı bir hastane modeli olarak tanımlanabilecek bu yapı, eğer bütüncül tıp anlayışı ile işleyecek ise, şimdiden yapısal, personel ve idari önlem ve değişikliklerin göz önüne alınması yararlı olacaktır.

Çalışmanın bazı kısıtları

Araştırma sürerken, öncesinde yahut sonrasında bazı pratik ve kavramsal zorluklarla da karşılaştım. Örneğin GTTU'na ait yazında da tıpkı mevzuatta olduğu gibi kavramlar arasında bir belirsizlik ve bağlamsal tanımlamalar mevcuttu. Bu durum hem sistematik veri taramasını zorlaştırdı. Hem de zaman kaybına neden oldu.

Ayrıca Türkiye'de konuyla alakalı yapılmış nitel ya da nicel kapsamlı, ülke sathını kapsayan çalışmaların yetersizliği, araştırmaya başlarken dahi kuramsal çerçeveyi oluşturmada sıkıntı oluşturdu.

Katılımcılar çalışmanın diğer bir kısıtı idi. Şöyle ki, her bir katılımcı sadece kendi bildiği ve kullandığı GTTU (lar) üzerinden konuşmayı tercih etti. Bu durum, profesyonellerin konuya

bütüncül bakışı hakkında fikir edinmemi engelledi. Bazı mülakatlarda konuşma örneğin sadece akupunktur üzerinde dolanmaya başladı ve verinin kalitesini düşürdü. Alana bütüncül bakabilen profesyonel sayısı düzenleme yeni olduğu için çok azdı.

Son olarak, araştırmacı olarak ben, çalışmanın bir diğer kısıtını oluşturdum. Nitel araştırmalarda araştırmacı ve katılımcı arasındaki yansıma kaçınılmazdır (Berg, 2001). Bunun farkında olup, araştırmayı ve analizleri bunu dikkate alarak yapmaya çalıştım. Ancak yine de bazı katılımcıların beni Sağlık Bakanlığı çalışanı gibi görmesi, sonuçları bakanlığa bildireceğimi düşünmeleri ve hatta bunu önermeleri gibi durumlarla karşılaştım. Ayrıca bazı katılımcılar için, GTTU'nın bazıları hakkında ön bilgimin olduğu (hacamat gibi) var sayılarak mülakatın ilerlemesi verinin kalitesine etki etti. Yine de etik kurallara uyma sayesinde de araştırmanın güvenilirliğini sağlamaya çalıştım.

Gelecek çalışmalar için öneriler

Bulguların ışığında, bu araştırmada yeterince değinilemeyen ancak ileride çalışılmasının kurama katkı sağlayacağını düşündüğüm birkaç husus ile özeti bitirmek istiyorum.

Öncelikle, meşruiyet yazını açısından 'meşruiyet kriterinin meşruiyeti' meselesinin daha derinlemesine çalışılmasının kuramsal katkı sağlayacağını düşünmekteyim.

Bunun dışında, meşrulaşma sürecini açıkladığını anlattığım üç boyuttan biri olan profesyonellerin, bireysel nitelikleri bu çalışmada yeterince belirlenemedi. Doğru bir araştırma deseni ile, hem kimlikler hem de kurumsal mantıklar açısından meşruiyet kriteri tercihleri ve profesyonel bölünmenin derinlemesine ele alınmasının fayda sağlayacağını düşünüyorum. Bu tarz bir çalışma, sadece betimleyici değil neden-sonuç ilişkisini anlatacak bulgularda sunabilecektir.

APPENDIX J. CURRICULUM VITAE

Personal Information

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Education

Ph.D.	Management and Organization	GPA: 3,81/4,0	Ankara Yıldırım Beyazıt University, 2012-All but dissertation
M.B.A.	Business Administration	Ranked 1st (Institute) GPA: 3,9/4,0	İstanbul Fatih University, İstanbul, 2005-2006
B.Sc.	Business Administration (English)	Ranked 1st (Business Department) Ranked 1st (Faculty) GPA: 3,83/4,0	Marmara University, İstanbul, 1998- 2003
High School	Nurullah Koyuncuoğlu High School	Ranked 4th GPA: 4,95/5,0	Simav, Kütahya, 1995-1998
Elementary School	Osmanbey Elementary School		Simav, Kütahya Türkiye, 1991

Publications (Printed Refereed Journal)

Aysan, H. “Conflicting Institutional Logics in the Religious Context of Islam”, Journal of Management & Organization Studies, April 2017, C. 2, S. 1, s. 49-70.

Workshop Papers

7th Organization Theory Workshop - Marmara University: Dışlanmış Uygulamaların Örgütsel Alanlara Yeniden Girişi: Türk Sağlık Sisteminde Geleneksel ve Tamamlayıcı tıp uygulamaları, Istanbul, 4-6 February 2016

EGOS & Organization Studies & Organization and Management Theory Division of Academy of Management 2nd Central and Eastern European (CEE) Workshop- Mykolas Romeris University - Pre-University level business education in Turkey: Trade Vocational Schools in 1883-1995, Vilnius, 27-28 October 2016

13th New Institutionalism Workshop- The Hebrew University of Jerusalem- Institutional entrepreneurship in Vague Fields: Religious Affairs Field of Turkey, Jerusalem, 19-20 March 2017

Congress Papers

24th Management and Organization Congress– Sabancı University: Dışlanmış Uygulamaların Örgütsel Alanlara Yeniden Girişi: Türk Sağlık Sisteminde Geleneksel ve Tamamlayıcı tıp uygulamaları, 2014-2016, İstanbul, 29-31 May 2016

32nd EGOS Colloquium – University of Naples Frederico II –Relegitimating an Outcast Practice: Professional Contestation over Introduction of Traditional and Complementary Medicine into Turkish Health Care System, 2014 – 2016, Napoli, 7-9 July 2016

33th EGOS Colloquium – Copenhagen Business School- Change in pre-university level business education: Turkish trade vocational schools, Copenhagen, 6-8 July 2017

Awards and Distinctions

TÜBİTAK 2224A Scholarship Programme for the support of Foreign Scientific Activity (2017)

TÜBİTAK 2211 National Scholarship Programme for PhD Students (2014-2016)

Marmara University Bachelor’s Degree, First rank of Faculty and Department (2003)

ÖSYS 302th rank of Turkish University Entrance Exam (1998)

Languages

Advanced English, Primary German and French