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ORIGINAL ARTICLE

Complementary and Alternative Medicine legitimation efforts in a hostile environment: The case of Portugal

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Abstract

This article explores complementary and alternative medicine (CAM) organisations' legitimation efforts that face extra obstacles as they are subject to more than one institutional logics (hybrids) and operate in a contested organisational space (hostile environment). CAM organisations espouse the health and market logics and their practices are questioned at an institutional level. The study is conducted in Portugal, where the legalisation of CAM therapies was a contested process over 10 years. Taking an abductive approach and drawing on qualitative interviews, the authors analyse CAM managers' efforts to legitimise their practices and build viable organisations despite hostile conditions. Contrary to prior studies of hybrid healthcare organisations, CAM organisations derive moral legitimacy from the market logic rather than the health logic. The findings show that relationships, trust-building and consumer education appear to be the primary vehicles for establishing pragmatic legitimacy. Thus, pragmatic legitimacy relies on the health logic. The market logic dominates the pursuit of moral legitimacy through financial sustainability, human capital, marketing communications and

partnerships, and advocating complementarity with biomedicine. We propose a model through which organisations use pragmatic legitimacy to enhance moral legitimacy and to create recursive feedback between moral and pragmatic legitimacy on the path to cognitive legitimacy.

KEYWORDS
complementary and alternative medicine, hostile environment, hybrid organisations, legitimacy

INTRODUCTION

> A hospital is unlikely to lose legitimacy simply because some patients die; however, it is quite likely to lose legitimacy if it performs involuntary exorcisms—even if all patients get well.
>
> Suchman (1995, p. 580)

The legitimacy of healing therapies can be paradoxical as even positive outcomes cannot guarantee acceptability if the practices are viewed as dubious. In an organisational context of health care, in which outcomes are uncertain, legitimacy takes refuge in professionally codified procedures (Ruef & Scott, 1998; Suchman, 1995). In such cases, 'sound practices' stand for following endorsed procedures towards an outcome that may be hard to observe. Consequently, organisations are less likely to be penalised if they follow legitimised procedures.

Complementary and Alternative Medicine (CAM)[1] is a good context in which to explore legitimation mechanisms in the face of internal and external obstacles. CAM organisations' professionalism and practices are contested (Lewis, 2019). CAM encompasses health practices that fall outside of mainstream health care such as acupuncture, homoeopathy, osteopathy, naturopathy, phytotherapy and chiropractic, among others, which differ from country to country (Fjær et al., 2020). They are often derided in Western societies[2] because CAM is perceived as not rooted in the scientific method (Crawford, 2016). Doubt about the effectiveness of CAM has encouraged various programmes to gather scientific evidence and some therapies with longer standing in higher education institutions such as osteopathy, chiropractic, naturopathy and Chinese medicine, which have been more successful in this aspect (Brosnan et al., 2018; Derkatch, 2008, 2012). Regardless of the controversies surrounding it, the CAM market is estimated to reach US$ 404 billion worldwide by 2028 (Grand View Research, 2021). CAM organisations use market mechanisms to grow their dual mission, which marks their hybridity—health care and profitability. Yet, individual organisations face environmental hostility and accordingly need to embark on their own legitimation voyage.

Hybrid organising has been defined 'as the activities, structures, processes and meanings by which organisations make sense of and combine *multiple* organisational forms' (Battilana & Lee, 2014, p. 398). Hybridity in health care could be defined as any combination of the four logics specifying the main organisational forms in the sector: private, public, profit and nonprofit (Caronna, 2011). While conventional health-care facilities such as hospitals in European states combine elements of public, profit and non-profit organisations (Martin et al., 2021), CAM

organisations are predominantly private, but even if they are for-profit, they are not typical businesses subject only to the market logic. When hybrid configurations merge elements from different organisational forms they often experience conflicting pressures from different institutional logics (Ebrahim et al., 2014). Institutional logics are socially constructed practices and values through which individuals and organisations organise and reproduce their material subsistence and infuse it with meaning encompassing the structural, normative and symbolic dimensions (Thornton & Ocasio, 2017).

Successful outcomes are difficult to articulate for hybrid organisations due to the combination of distinct institutional logics (e.g. profit and non-profit) (Battilana & Lee, 2014; Rosser et al., 2021) and the hybrid identity of their leaders (e.g. manager vs. health practitioner) (Martin et al., 2021; Numerato et al., 2012). Hostile environments disputing the legitimacy of particular practices present further obstacles by contesting and obstructing hybrids, questioning even positive outcomes (Hsu et al., 2018). Accordingly, we ask how hybrid contested organisations can carve out a legitimation path.

We delve into CAM establishments' legitimising activities via a qualitative abductive study resting on Suchman's (1995) strategic legitimacy as an organising framework. The data collection was conducted in Portugal, where the legalisation of CAM therapies was a long and contested process. The findings indicate that CAM organisations rely on relationship and trust-building and consumer education to establish pragmatic legitimacy leaning mostly on the health/care logic. They pursue moral legitimacy via the primacy of the market logic through hybrid organisational forms, human capital development, marketing communications, formalisation of procedures and complementarity to biomedicine. These findings differ from prior ones showing mainstream hospitals sourcing moral legitimacy from the health/care logic (Marnoch et al., 2000; Martin et al., 2021). Subsequently, we propose a mechanism through which these organisations use pragmatic legitimacy to enhance moral legitimacy and to create recursive feedback of legitimacy gains.

STRATEGIC LEGITIMACY IN A HOSTILE ENVIRONMENT

The strategic view implies a high level of managerial control over the legitimation process moving through three different kinds of legitimacy from less to more significant: pragmatic, moral and cognitive (Suchman, 1995). *Pragmatic* legitimacy is obtained when an organisation is recognised by a stakeholder group because of the benefit it provides to that group. Evidence suggests that many people turn to CAM services when their problems have not been resolved by biomedicine even when therapies are not formally recognised (Kelner & Wellman, 1997; Welsh et al., 2004). For example, if an audience deems homoeopathy valuable, then it grants pragmatic legitimacy to the practice regardless of the general social attitudes towards it (Crawford, 2016). A case in point is the legalisation of medical marijuana in the US, which had to undergo a long process of de-stigmatisation after achieving a level of pragmatic legitimacy due to the self-interest of the individual actors involved in the struggle for legalisation (Lashley & Pollock, 2020). Nevertheless, pragmatic legitimacy is fickle and very much dependent on the predominant salient group of stakeholders at any given time, which makes it subject to continuous negotiation and contestation (Dodworth & Stewart, 2022).

Moral legitimacy is normative and based on an evaluation of whether the organisation's activity is 'the right thing to do' relative to social norms and judgements, and these are evaluated by their outcomes/consequences, procedures or structures (Suchman, 1995, p. 579). While

pragmatic legitimacy could be managed at the organisational level, moral legitimacy is more likely granted to the market category or professional field. The organisation cannot control moral legitimacy directly as it rises and falls according to society's beliefs. Lashley and Pollock (2020) describe the infusion of morality in the legitimation struggle for the acceptance of medical marijuana by appealing to patients' rights, medical studies, building ties with local communities and other activities accepted as 'right'.

In the context of health care, *procedural* legitimacy, which builds on the soundness of procedures is of particular significance as 'prevailing rational myths... often specify extensive webs of causality, identifying some methodologies as "science" and others as "quackery"' (Suchman, 1995, p. 580). Procedural legitimacy is especially important if uncertain outcomes are socially acceptable (e.g. health care) and/or a high degree of uncertainty surrounds the organisational form (e.g. hybridity). Thus, due to questionable efficacy claims regarding CAM, *procedural* legitimacy becomes paramount (Crawford, 2016; Derkatch, 2008).

Finally, *cognitive* legitimacy is the most complex form of legitimacy. An organisation with cognitive legitimacy benefits from being taken-for-granted—it is so obviously valuable that it is accepted without a deliberate evaluation exercise; its activities and actions are fully congruent with established rules and norms (Suchman, 1995). Interestingly, Marnoch et al. (2000) claim that the introduction of business-like managerial practices to the National Health System (NHS) hospitals enhanced their cognitive legitimacy.

Hybrid organisations are subject to both competing institutional pressures (Pache & Santos, 2013) and internal identity conflicts (Numerato et al., 2012). Due to their mission orientation, it is common for managers of hybrids to feel tension with organising for profit while simultaneously acknowledging that profits would further their mission (Hahn & Ince, 2016). However, when a hybrid organisation is embedded in a hostile environment, its mission could be questioned. Such challenges can exacerbate legitimation obstacles even in a growing market category (Hsu et al., 2018; Washburn & Klein, 2016). How organisations would choose to overcome legitimacy hurdles might depend on the conflicting demands they face from their different audiences (Hsu et al., 2018), which could be especially challenging in contested categories.

Environmental hostility has been defined as 'the scarcity of external resources and opportunities in a specific environment' (Tang & Hull, 2012, p. 133). Khandwalla (1977) suggested that hostile environments could be found in four formats: market decline, restrictiveness, competition and resource scarcity. In the context of CAM, market decline and restrictiveness could occur when demand falls due to open criticism or purposeful actions of public bodies to shrink CAM facilities, as exemplified in the case of homoeopathic hospitals that were removed from the NHS in the UK and the story of one of the only two surviving CAM hospitals—the Glasgow Centre for Integrative Care (GCIC) (Crawford, 2016; Dodworth & Stewart, 2022). The story of the journey of GCIC is an example of 'the constraints placed on firms by their external constituents' (...) 'through norms, policies and regulations' (Kach et al., 2016, p. 910).

Another example of hostility is demonstrated in the case study of a women's care clinic that came about through legislative (abortion restrictions), direct (vandalism) and fiscal (restricting insurance and fundraising) actions (Hyde, 2008). Also, competition in the form of biomedicine discrediting CAM services as nonscientific in an environment poor in critical resources increases hostility and makes the path to CAM legitimacy thornier (Derkatch, 2008, 2012). For instance, Western societies' shared knowledge of health care is established in biomedicine in contrast to CAM practices originating in ancient traditions (Derkatch, 2012; Nissen & Manderson, 2013). Finally, an ambiguous regulatory environment can substantially increase the vulnerability of organisations whose activities are questioned by powerful societal groups. The bottom line is

that environmental hostility can exist in various forms and originate from different audiences; therefore, organisations seek to minimise scrutiny from those that are the most hostile (Hudson & Okhuysen, 2009).

RESEARCH CONTEXT

The context of CAM is characterised by environmental hostility (Dodworth & Stewart, 2022; Nissen & Manderson, 2013). Previous studies have discussed the hybrid nature of CAM organisations and practices (Bicho et al., 2022; Dodworth & Stewart, 2022; Gale, 2014; Keshet, 2010). Of the four institutional logics recognised to operate in healthcare—professional, market, corporate, state (Reay et al., 2017)—only two are relevant to CAM organisations as they are too small for the corporate logic and usually operate outside of state-sponsored health care. We thus focus on the health and market logics (i.e. 'health/care' and 'business/profit'; Bicho et al., 2022). We replace the professional logic with health/care because professionalisation efforts are still a work in progress in CAM (Welsh et al., 2004) and because our data led us to the health/care logic. However, the parallels are quite close. What Martin et al. (2021) present as evidence of the clash between the professional (care for patients) and the market logic (efficiency, profit orientation) is almost identical to what we observe in our data. CAM differs from mainstream medicine because its origins are found outside of the scientific paradigm (Derkatch, 2008; Fjær et al., 2020), although there is a growing evidence base for certain plant-based medicines, such as cannabis[3] (Lashley & Pollock, 2020). In fact, CAM's identity is *in relation to* conventional medicine—'complementary' signifies that practices are used to complement conventional medicine, whereas 'alternative' signifies practices replacing conventional medicine (Fjær et al., 2020; Nissen & Manderson, 2013).

CAM organisations try to address some of the gaps in Western health care (Siahpush, 1998) by proposing personalised (Deml et al., 2019), preventive and holistic health services (Barrett et al., 2003); by empowering patients through co-creation of health solutions (Dodds et al., 2018); by the use of natural remedies as opposed to drugs (Hirschkorn, 2006); and by attempting to treat the cause rather than the symptoms of health problems (Hirschkorn, 2006). Nevertheless, they encounter legitimacy obstacles. CAM's marginalised status arises from its 'otherness' (Hirschkorn, 2006), though active legitimation work has moved the needle towards greater acceptance of the practices in recent decades (Dodworth & Stewart, 2022). CAM practices have remained mostly outside the conventional health sector (Almeida & Gabe, 2016; Brosnan, 2017; Derkatch, 2012; Wardle & Adams, 2014).

Even some of the more established CAM categories such as chiropractic are at constant risk of delegitimation (Brosnan, 2017). CAM practices tend to be associated with 'quackery', 'irregular' and 'alternative', in contrast to the 'regular' or 'orthodox' profession of biomedicine commonly used to describe established health practices (Gale, 2014; Lewis, 2019; Polich et al., 2010). Because some of their basic assumptions fall outside the boundaries of biomedicine (Derkatch, 2012; Mizrachi et al., 2005), CAM practices tend to be looked at with hostility (Brosnan, 2017).

The paucity of legal structures regulating CAM practices has put at risk CAM users as well as CAM practitioners (Crawford, 2016). Another hurdle is that accredited CAM degrees are scarce, with some notable exceptions such as osteopathy or Traditional Chinese Medicine degrees, risking poor training standards (Wardle & Adams, 2014). Studies have shown that some of the risks associated with the lack of scientific studies, policy frameworks and education include inadequate training of CAM practitioners, misleading consultations and exploitation of patients

(Crawford, 2016; Wardle & Adams, 2014). As Dodworth and Stewart (2022, p. 245) point out, 'CAM and mainstream biomedical science draw on conflicting systems of knowledge and belief, practice and care, power and authority and ultimately legitimation'. Accordingly, CAM organisations face a hostile environment as they are controversial and marginalised by biomedicine and societal institutions, and simultaneously experience intense market and resource access restrictions (Bicho et al., 2022; Dodworth & Stewart, 2022).

The Portuguese context is a good example because the regulation of CAM practices went through a difficult legislation process of more than 10 years as powerful institutional forces delayed the regulation of CAM practices (Almeida & Gabe, 2016). Examining the Portuguese case also responds to a call for non-Anglo-Saxon-centred research in the field (Numerato et al., 2012). The first attempt to regulate CAM practices in Portugal was in 2003 (Law nº45/2003) but it took 10 years for the law to come into effect in 2013 (Law nº 71/2013). The law legalised seven therapies: Acupuncture, Homoeopathy, Osteopathy, Naturopathy, Phytotherapy, Chiropractic and Traditional Chinese Medicine. The 2013 law defined non-conventional therapies as '*those that start from a different philosophical basis from conventional medicine and apply distinct diagnostic and therapeutic procedures*' (please find in the Supporting Information S1 the evolution of the CAM regulation in Portugal).

The law listed basic guidelines, such as general guiding principles and ethics for the exercise of CAM regarding public health and individual rights. It posited that CAM practices should be governed by the same law as conventional medicine. In 2015, the Ministries of Health and Education and Science regulated the general requirements that must be satisfied by an undergraduate degree in acupuncture, naturopathy, chiropractic, phytotherapy and osteopathy followed in 2018 by requirements for a degree in Traditional Chinese Medicine. The Portuguese Ministry of Higher Education approved only two undergraduate programmes—osteopathy and acupuncture—mostly offered by private higher education institutes. This prolonged process featured disagreements about and scrutiny of the benefits of CAM practices.

METHOD AND DATA

We interviewed founders/managers of CAM organisations offering the therapies legalised in Portugal: Acupuncture, Homoeopathy, Osteopathy, Naturopathy, Phytotherapy, Chiropractic and Traditional Chinese Medicine. Under Portuguese law, CAM organisations may be established as clinics[4] (following the model of medical clinics) or as centres offering well-being services. We talked to either the founder (the person that founded the CAM establishment) or the manager (the person in charge of managing the CAM organisation who may or may not be the founder). We refer to therapists and providers of well-being services as CAM practitioners. In this study, most of the interviewees are simultaneously founders, managers and practitioners; only four out of 40 are managers who are not trained as practitioners (see Table WA1 in the Supporting Information S1). The scope of the study includes CAM therapies (please find all the practices included in this study in Table WA1) but not integrative practices that might include medical doctors, physiotherapists, dieticians, psychologists and other health professionals.

We employed the abductive method using qualitative analysis aimed at theory construction/modification (Timmermans & Tavory, 2012). Abduction is acknowledged to facilitate a richer understanding of phenomena with the guidance of theory and involves an iterative process between empirical findings and existing theory (Agar, 2010). Since the goal of this study is to understand organisations' legitimation efforts in a hostile context, abduction is suitable

as it allows entering the field with a theoretical base guiding the analysis of empirical data (Agar, 2010; Timmermans & Tavory, 2012). Legitimacy offers a very rich theoretical foundation, and abduction permits the flexibility between theoretical rigour and field-inspired novel insights.

The data were collected from semi-structured interviews in 2012, 2013 and 2019, before and after the legislation that regulates CAM practice (2013). The initial set of interviews revealed that before the legislation CAM practitioners operated in limbo. The absence of laws and regulations was impacting the legitimation efforts of CAM organisations. Therefore, we collected another set of interviews to see how perceptions evolved after the passing of all regulations that had been in deliberation for more than 10 years.

Portuguese CAM establishments (usually designated as clinics or centres) are very small, most having fewer than 10 employees and less than 2M€ revenue and are typically managed by their founder. Sampling criteria included establishments offering one or more of the seven legalised practices in Portugal. A purposive sampling technique was employed to enhance the reliability and representation of the study setting. Respondents were identified based on referrals given from the interviewees and other CAM practitioners and publicly available sources. We interviewed founders/managers of 40 Portuguese CAM organisations, as they are responsible for making the most important organisational decisions referring to organisational identity, strategy and growth, as well as hiring and management practices.

Our sampling strategy was guided by the principle of adding interviews until no incremental insights were generated with each new informant (Saunders & Townsend, 2016). Table WA1 presents CAM organisations' characteristics, therapies offered, and respondents' profiles. We built an interview protocol with 10 questions addressing the managers' responses to legitimacy demands that covered the following themes: perception of CAM practices and their legitimacy; communication and trust-building efforts; issues of training; hiring procedures and competencies; and institutional status of CAM practices. Ethics approval for this study was obtained from the institution of the authors.

The first author, who has considerable experience in the field, both as a CAM manager and a scholar, conducted the interviews in Portuguese. The translation of the responses into English was performed and verified by two of the authors who are fluent in English and Portuguese. The first part of the interview was dedicated to securing informed consent guaranteeing anonymity to the interviewees. The semi-structured interviews lasted between 30 and 105 min. Most of the interviews were conducted face to face, and 15 interviews were conducted via Skype. All the interviews were recorded and transcribed *verbatim* thereafter to ensure reliability. The content was coded in NVivo 12. Data analysis proceeded iteratively. We employed a thematic analysis (Cassell & Bishop, 2019; Nowell et al., 2017) and followed the process suggested by King and Brooks (2018). Thematic analysis is suitable for an abductive approach since it facilitates the iterative process between findings along with existing theoretical knowledge. The data were analysed in the following way: we first read the transcriptions to become familiar with the data, while taking notes and generating initial codes. We then searched for themes while systematising and organising the data. While going back and forth between data and theory, we revised the themes until we had formally classified all of them. We used this coding process after the first (2012–2013) and second (2019) rounds of interviews and refined the analysis based on the insights that emerged. Finally, we moved on to the interpretation of the main themes, which were independently revised by two of the authors, which enabled us to validate the themes and interpretations.

FINDINGS

CAM managers take various steps to legitimise their organisations. Broadly, they try to clarify the value proposition for their clients to gain pragmatic legitimacy and acquire societal-level moral legitimacy through market-based logic. Value creation targets consumers by offering well-being solutions, committing to relationship building and educating the general population about CAM. Attempts to gain moral legitimacy stem from market decisions—choosing a hybrid organisational form that centres on health care, which is nevertheless run for profit; developing human capital in terms of professional training and certifications as well as recruiting employees with good interpersonal skills and values alignment; and investing in marketing communications and partnerships. CAM managers also acknowledge the important role of government regulations in the legitimation process. The findings organised by the key themes arising from the interviews are summarised in Table 1.

Trust building efforts

Trust building is vital in situations in which legitimacy is questioned and even more so when health is of concern (Pedersen et al., 2016). Respondents deliberately use trust-building mechanisms *during* CAM service (simultaneous production and consumption) and expect it to be awarded *after* good quality service delivery. Such assumptions have been confirmed in previous research reporting that users' experience during treatment and the effects of the treatment are important in their trust in CAM practitioners (Pedersen & Baarts, 2010; Pedersen et al., 2016). CAM providers' efforts to build trust *during* service delivery include detailed procedure disclosure:

> Explaining what I do, making sure they know what is being done, why, by whom, where I come from.
>
> (24)

Honesty is another vehicle used to build trust. Some respondents explicitly stated that when they do not know how to help the patient or when they cannot offer the appropriate solution, they are upfront about it.

> *(...)* know how to admit what we don't know, or what it is not for us to treat. (...) by managing to tell the patient that this is not for me. If I manage to put this level of honesty in all patients [...] that in terms of trust, it is what the patient needs.
>
> (38)

Trust building also includes the appointment duration, on average 45 min, which allows for more rapport with patients, as opposed to the average 15 min appointment with a physician.

> I think it's the time we dedicate to them, they realise that when they enter the appointment and don't have a specific time to leave—that we're not there to be in a hurry. Unfortunately, especially in the NHS, they feel that a lot, and this is the feedback that I have from many patients, that it's me not looking at the clock.
>
> (12)

TABLE 1 Themes, sub-themes, and illustrative quotes.

Theme	Subthemes	Illustrative quotes
Trust building efforts (PL)	Health service delivery	(...) I explain everything in detail and that's how I conquer trust. (2)
		The outcomes! And the outcomes not only in the client himself but also in his friends, in the family he brings with him or through whom he ends up here. (26)
	Outcomes	They believe because they have trust and outcomes. If they didn't have outcomes they wouldn't look [for me]. (17)
Legitimacy efforts (PL)	Educate about CAM	Yes, that I also think is important, in reality, everything that can be done to make information reach people—what is each specialty and on what it can have an effect,—show concrete cases. (4)
	Advocate complementary with biomedicine	I try to always incentivise a relation with the doctors because many people come here because there were no results and then we share that patient [...] I send a report to the doctor saying we did this or that, and I suggest this or that based on what I saw [...] and there are more and more doctors recognising what we do and accepting our message. (32)
	Legal environment	I think that first of all its legalising the areas of alternative medicine (...) first is legalise because by legalising there is more control, we know in which areas what we are doing and not doing (...) and that is the most important. Then, we can explain more clearly what is that we do. (33)

(Continues)

TABLE 1 (Continued)

Theme	Subthemes	Illustrative quotes
Human capital (ML)	Therapeutic skills	A primary competence for me is public safety—I think the first priority is safety. [...] He [the practitioner] must be competent in the osteopathic principles, he must understand what osteopathy is, what kind of approach and identity the profession has and he must use the osteopathic reasoning, which is what in reality distinguishes us from other professions, he must know how to use the practice based on the needs of the patients that occur. (20)
	Referrals	Usually, people who have been coming are recommended [to the manager] by others who have already worked here. (4)
	Professional license	They have to have a degree, there are bachelors of Chinese Medicine, they have to have the complete degree, to be able to practice. (1)
	Academic training	They must have a course in the area recognised by an entity that we know and that we know that exists and have to show all the documentation at the level of diplomas, certificates. (4)
	Social skills	Undoubtedly empathy and the ability to communicate and relate to people are very important. (27)
	Values alignment	There must be an alignment with our image, with our principles, more than anything else. (26)

TABLE 1 (Continued)

Theme	Subthemes	Illustrative quotes
Marketing communications and partnerships (ML)	Partnerships	Yes, we have a lot of them [partnerships with companies]. (37)
	Communication platforms	We write articles, we feed the website, Facebook and Instagram, and the testimonies come in handy, I have a testimonial book, we share it on the website and then we publish it on Instagram. (31)
	Word-of mouth	The clients we have are all from word-of-mouth. For me it is the marketing that works the best and that makes the most sense to me. (6)
Hybrid organisational form (ML)	Hybridity	There is no business whose purpose is not profit and be profitable [...] but here it has a secondary status [...]. (4)
	Financial sustainability	Management here is the main thing [...] it is important having the financial management under control. (4)
		The revenue must always be reinvested. (8)

Trust is also believed to be awarded by clients *after* the service delivery as it depends on perceived *outcomes*:

> I think it's the outcomes. So the person feels better and trusts us more and step by step. I think that's the secret.
>
> (32)

> Trust in the therapist [...] obviously the outcomes they have from the treatments.
>
> (22)

In a field that is characterised by uncertain outcomes, the bar for CAM seems to be rather high: not only must practitioners commit to reducing potential client risk perception or uncertainty through trust-building efforts but also patients will trust the provider only if they observe positive outcomes. For instance, a patient will not distrust a biomedicine practice just because it did not solve their health problem, however, the same is not true regarding a CAM practice. Such double standards are found in scientific discourse too, where the rigour of evidence required for CAM therapies is much higher than for biomedicine (Derkatch, 2008). No differences were found before and after the passing of CAM laws. Consequently, even with regulation, CAM practices are still under scrutiny and discussed in the public arena, and trust-building efforts are essential.

Legitimation efforts—Education, advocacy, legal environment

Interviewees promote CAM acceptance by educating consumers, key stakeholders and the public about CAM. Information techniques mentioned include newspaper and magazine articles about CAM therapies and their benefits, online media content including websites and social media, public talks, seminars and conferences and participation in TV shows. Most of the content focusses on explaining what CAM practices are and showcasing successful outcomes as well as what CAM *is not*—esoteric practices. Educating efforts are necessary because CAM is met with controversy and suspicion. Such observations confirm previous findings of hybrids using rationality as a vehicle for obtaining credibility and legitimacy (Brosnan, 2017; Jayawarna et al., 2020):

> [...] the most important thing is the information sessions because [CAM] is an area that has to do with information and with credibility so if managers of this type of centre want to attract a client, they must capture its confidence they must explain what it consists of.
>
> (10)

Respondents do not wish to be associated with snake-oil practices:

> Because if you mix things, the credibility can be less, because there are people who do not want to hear about esotericism, [...] people get confused and it creates distrust.
>
> (1)

Some respondents emphasised the benefits of reaching out to the medical community highlighting the *complementary* role of CAM and providing evidence of successful cooperation:

> [...] Here we can do very interesting complementary work, here we have several cases of people with an oncological situation in IPO (Portuguese Oncology Institute) and simultaneously being treated here, and that, I think it is very important to disseminate.
>
> (4)

> Probably we can try to improve communication with conventional medicine in a way to be able to work that is really teamwork.
>
> (27)

Prior research has also noted practitioners' preference for 'complementarity' rather than alternative to conventional medicine (Brosnan, 2017). Integrating practices with biomedicine is viewed as a structural legitimacy claim within the umbrella of moral legitimacy (Crawford, 2016). Perhaps not surprisingly, direct customer education efforts are prioritised when compared with advocacy efforts directed at physicians. The education efforts are reflected in the responses in 2012, 2013 and also in 2019, as educating consumers and the public is a continuous path of legitimacy building.

In addition, the findings suggest that CAM providers recognise that being proactive is not enough to be granted legitimacy. Legal recognition and regulation are stated as key in clarifying legal requirements such as tax refunds, as well as increasing trust and transparency:

> This does not depend only on us. I think this comes from the Government's acceptance and from the juridical implementation and documentation of our therapies (...). And that also led to a lack of credibility of the therapists for a long time (...).
>
> (11)

> Regulation, be it good or bad for these establishments [...] is the best for the patient. [...] But above all what will happen in transparency [...].
>
> (3)

When it comes to perceived environmental hostility, we did not find any differences in the interviews across the regulation span.

> The (CAM) therapeutics continue to be frequently attacked, mainly from the medical point of view, from the point of view of lack of evidence, of rigour and evidence.
>
> (23)

Even after legalisation, CAM practices are still under scrutiny and are frequently attacked, suggesting that gaining legitimacy could be a long path. Prior studies have identified that this path requires scientific evidence about CAM practices and outcomes (Brosnan, 2017).

Human capital

Prior studies have shown human capital to be an important legitimacy building block (Brosnan, 2017; Jayawarna et al., 2020) and we find similar undertones. Academic training and technical (therapeutic) skills are crucial when selecting practitioners. Therapeutic skills, considered by managers to be of utmost importance, refer to CAM practitioners' practical knowledge to master various aspects of diagnoses and treatments such as massage, acupuncture, chiropractic etc.

> Excellent knowledge of anatomy, good symptomatic analysis.
>
> (38)

Academic training concerns knowledge that CAM practitioners obtained in instructional courses and schools. Degrees and certificates from recognised schools are complements to therapeutic skills. Since CAM practices still face legitimacy hurdles, good training is a signal of the expertise of CAM practitioners, ensuring the soundness of the practice and the safety of the patient (Welsh et al., 2004).

In Portugal, the requirements of a study cycle leading to a degree in acupuncture, naturopathy, chiropractic, phytotherapy and osteopathy were published by the government in 2015. The first CAM undergraduate degree in osteopathy (minimum 3-year course) was approved in 2016, followed by acupuncture in 2017. This explains why few CAM practitioners in our sample have an undergraduate degree in CAM. Nevertheless, the degree of acupuncture approved in 2017 was not accredited by the Higher Education Agency in the re-accreditation process of the study cycle that occurred in 2021 (A3ES, 2021). The main reasons invoked were the lack of professors with a PhD in the area of the course and permanent staff, the low production of scientific activity in

the area of acupuncture, and the difficulty in harmonising the scientific language in Portuguese (A3ES, 2021). It is worth mentioning that all professors had proven professional experience in the field, and that in Portugal, as of now, there is no institution offering a PhD in any of the practices of non-conventional medicine, and therefore, most of the literature is in international scientific journals.

For some establishments, a professional license and registration in the General Directorate of Health is the main prerequisite for hiring, but all emphasised the importance of training obtained from a reputable school. Still, there is a preference to hire therapists whom the managers know or who were referred to them by other practitioners and to directly assess a candidate by simulating an appointment:

> [We need] to be careful with some people who call themselves alternative medicine therapists, [We need] to get a good look at people's curricula and training.
>
> (30)

> They must have a course in the area recognised by an entity that we know and that we know that exists and have to show all the documentation at the level of diplomas, certificates.
>
> (4)

> They always have to go through something, do tests with the doctors here.
>
> (1)

Training, however, is not enough per se. Overall, the competencies of CAM practitioners can be summarised in three main areas: technical skills, empathy and interpersonal communication skills.

> The skills that are sought in a professional essentially meet three major areas: technical skills, it is the basic knowledge in the health area [...] After this we have to verify if the person has the skills and abilities to establish an empathic relationship with patients, and this is often the biggest risk. [...] And then he/she has to be able to pass it on to the patient during the appointment. When these three points are gathered, we have guaranteed success.
>
> (28)

The findings reveal that even though managers start by indicating technical skills and academic training to be of utmost importance, they end up acknowledging social skills and values alignment as the ones that make the difference. The introduction of legal structural changes accounts for some modifications in hiring practices. In data collected during 2012 and 2013, before regulation and academic standards assessment, managers relied primarily on training and therapeutic skills evaluation in their hiring decisions. After 2019, having a professional license and registration in the General Directorate of Health became a legal requirement for hiring.

Marketing communications and partnerships

Given the trend of marketisation of health services, developing an effective marketing communications mix becomes a strategic necessity for health-care providers (Elrod & Fortenberry, 2020).

The main goal of such communication is to reach and engage with desired target audiences. Our data suggest (Table 1) that the prevalent marketing communications promote the CAM organisation and its services to consumers via online platforms, educate the public about CAM in mainstream media and build partnerships. Partnerships are established mostly with health insurers and with companies whose employees benefit from price discounts, aimed at health and wellbeing services provided either in the companies or in the CAM establishment. Respondents in 2019 indicated an increase in the partnerships with health insurers, made possible from the moment legal regulation of (some) CAM therapies was in place, and thus, partnerships with companies decreased. Respondents report that these agreements are not very profitable because fewer than expected consumers take advantage of them.

Consumer-initiated word of mouth founded on patients' experience is arguably a very important source of attracting new patients:

> The best way to do it and the way that has more impact is word-of-mouth, the satisfaction of our clients is what allows us the best promotion.
>
> (26)

Many CAM managers point out that traditional offline media, such as articles and promotions in specialised health magazines, does not generate a significant return. They have followed the consumer behaviour trend towards digital and invested heavily in online communication, including owned (e.g. blog, website, or social media channels) and paid media (e.g. social media ads, Google ads, etc.). The most popular are websites and Facebook pages allowing for communication with interested consumers as well as paid advertising driving online demand. These marketing communications efforts seem to aim at attracting consumers and educating public opinion about CAM for reputational gains.

> What I'm realising [...] is that Google pays off. [...] But it works very well, advertising through Google.
>
> (8)

> We write articles, we feed the website, Facebook and Instagram, and the testimonies come in handy, I have a testimonial book, we share it on the website and then we publish it on Instagram.
>
> (31)

While in 2012 and 2013 most marketing communications were offline, in 2019 there was a shift towards online communications in accordance with consumer migration to digital. Finally, the respondents in 2019 indicated an increase in the partnerships with health insurers as a result of the regulation.

Hybrid organisational form

All respondents in our sample reported tensions stemming from the hybrid organisational form, that is, on the one hand providing health services for patient well-being, and on the other hand being profit-oriented, focussing on financial sustainability. These forms are different from mainstream health clinics/hospitals in Portugal that are either public or owned by large corporations. The closest parallels are with private medical clinics that are also of hybrid forms albeit with much greater legitimacy and support from the state and insurance companies.

> There is no business whose purpose is not profit and be profitable [...] but here it has a secondary status [...].
>
> (4)

> Without false moralisms, above all, you have to like helping others. I think that the financial issue cannot come first, because if you work with the human being and work with what is most precious to the human being, health, you can't put money first.
>
> (12)

The findings suggest that financial sustainability is important for CAM organisations to focus on their core mission: health and well-being. Market success and profitability have been consistently used as a legitimacy validation tool in dual-purpose organisations (Jayawarna et al., 2020). By achieving financial sustainability, CAM organisations signal to the market that they are viable businesses, and thus respondents expect to gain more societal and institutional support.

DISCUSSION: A PRAGMATIC AND MORAL LEGITIMACY RECURSIVE PROCESS

CAM organisations offer contested services whose outcomes are not always immediately observable. Consequently, they do not have many legitimation resources within easy reach. To overcome this difficulty, CAM organisations leverage their advances in pragmatic legitimacy to create a positive recursive feedback cycle with moral legitimacy. CAM provides holistic health solutions and preventive care for enhanced well-being. Pragmatic legitimacy relies on clients' satisfaction and trust, which tend to be built on direct personal experience as well as on the perceived professionalism of providers (Pedersen & Baarts, 2010; Pedersen et al., 2016). Health services that patients perceive as valuable prevail over legal categories, feeding into pragmatic legitimacy (Boone & Özcan, 2020). CAM organisations engage in efforts to build pragmatic legitimacy, which they can use to enhance moral legitimacy resulting in more resources that can be injected back into higher levels of pragmatic legitimacy and so on, embarking on an evolutionary legitimation spiral from pragmatic to moral to cognitive legitimacy.

First, addressing consumer dissatisfaction with biomedicine and its inherent power imbalance between physicians and patients (Berry, 2019; Berry et al., 2017), CAM organisations accentuate relationship and trust building and consumer education and empowerment. By educating consumers about the importance of their role and responsibility for their well-being, CAM providers engage their clients in the healing process. Participation leads to higher perceived service quality and trust (Berry et al., 2017). It is not uncommon for hybrid (CAM) organisations to resort to constituency education as a way of enhancing and legitimising their mission (Brosnan, 2017; Hahn & Ince, 2016). By empowering consumers through education and meaningful engagement, CAM organisations offer customer value that leads to higher pragmatic legitimacy. It is important to establish pragmatic legitimacy with the direct beneficiaries as they are the most likely promoters and evangelists. Value creation through services addressing health and well-being problems can go a long way in compensating for unclear boundaries of CAM practices and legalisation issues (Boone & Özcan, 2020). This is a necessary phase as a major stepping stone towards the procurement of both financial and human resources. Even highly controversial organisations such as marijuana dispensaries and men's bathhouses can survive on the grounds of the pragmatic legitimacy conferred to them by their clients (Hudson & Okhuysen, 2009; Lashley &

Pollock, 2020; Washburn & Klein, 2016). Consequently, CAM organisations can achieve better financial performance by offering high value to clients by delivering results that they and other social actors can observe, building relationships with primary stakeholders and disseminating education about CAM therapies.

Second, gains in pragmatic legitimacy lead to better conditions for realising the dual purpose of CAM hybrid organisations—improving consumers' health and achieving profitability. CAM organisations can develop a business model capitalising on consumers' enhanced value perceptions by extracting higher economic profit and relying on customer referrals to grow their business. Notably, enhancing the value proposition relies primarily on the health logic. Educating and engaging consumers in taking active co-creation roles such as following protocols of taking herbal remedies, exercise/meditation regimens, changing diets etc. increases the chances of positive outcomes in terms of health and well-being. Leveraging financial profitability to advance the mission of the organisation is in the very DNA of hybrids (Hahn & Ince, 2016). Better financial health communicates the quality of the services (Barraket et al., 2016). Moreover, an emphasis on economic viability improves the organisations' ability to spread the social purpose of the organisation (Staessens et al., 2019). Subsequently, higher profits and a broader customer base lead to the growth and proliferation of CAM establishments.

Third, achieving stronger financial and health results allows CAM organisations to invest in human capital and take bigger strides towards professionalisation (Numerato et al., 2012). The market logic is the predominant driver of moral legitimacy enhancements. Financially, solvent organisations attract better-trained employees who are more versed in the importance of standards and procedures. Hiring practices can be an important tool for the prevention of internal conflict in hybrid organisations depending on the prevalent institutional goals (Pache & Santos, 2013). This is in contrast to mainstream health-care organisations, which mostly derive their moral legitimacy from the health/care logic (Marnoch et al., 2000). Because CAM practices are contested, they cannot be used as a source of moral legitimacy in a straightforward way. Thus, the legitimation process for CAM organisations follows a different trajectory from other mainstream health-care hybrid organisations.

Procedural legitimacy goes a long way in situations of uncertain outcomes (Suchman, 1995). While procedures per se do not give answers to why certain outcomes occur, adhering to procedures and tracing back the actions leading to an outcome can give us a chance to understand the cause of the outcome. Procedures are often linked to rationality and subsequently to its stamps of legitimacy approval (Tyler, 2006). Taken altogether, the different aspects of the moral legitimacy dimension—hybrid organisational form, human capital development, marketing communications and partnerships—work in synergy in advancing to a new level the pragmatic legitimacy dimension by delivering better services. Reinvesting the financial profits in the organisation, attracting better professionals and improving marketing increase customer value, which leads to more gains in pragmatic legitimacy moving the organisation to a higher level in the pursuit of moral legitimacy as well. Contrary to the often-portrayed conflict between social and economic missions, improved financial performance leads to superior offerings resulting in better dual mission outcomes (Staessens et al., 2019). The improved health outcomes are due to the higher level of professionalism—better financial prospects attract better-trained practitioners who can provide better care to clients generating broader societal support. The result is a recursive feedback mechanism between pragmatic and moral legitimacy reminiscent of the recursive legitimation process outlined by Barraket et al. (2016) and illustrated in Figure 1.

Market validation serves as a stamp of approval in contemporary society (Tyler, 2006). Legitimising institutions are more inclined to pay attention to growing market categories. Accordingly,

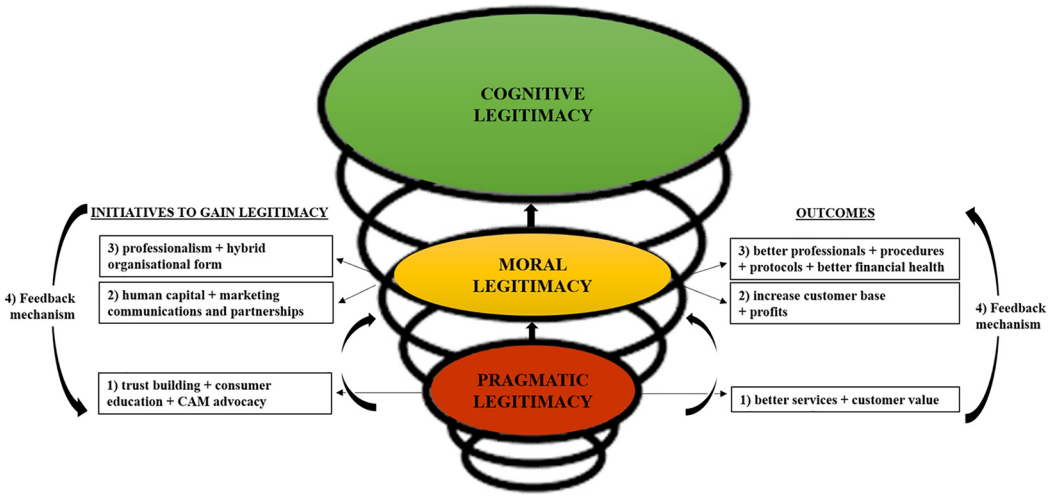

FIGURE 1 Legitimacy feedback mechanism.

CAM organisations can use profitability to invest in human capital development, partnerships and processes that would lead to further gains in moral legitimacy. Staessens et al. (2019) observe a direct relationship between stronger economic and social performance indicating that financially viable operations contribute to greater legitimacy. As legitimacy is not static, but rather constantly renegotiated (Suddaby et al., 2017), it is important to create mechanisms for the resources accrued through pragmatic and moral legitimacy to be put to work to move the organisation to higher levels of legitimacy (cognitive) (Rosser et al., 2021). 'Re-investing' moral legitimacy gains into pragmatic legitimacy gains and vice versa would create a recursive feedback effect reinforcing the two types of legitimacy. Hiring better-trained practitioners would help with establishing more effective and reassuring procedures and that would feed into delivering higher customer value and financial performance.

Even if some procedures are performative in essence, they could still contribute to enhanced customer value as patients would feel less anxious and more comfortable in settings that communicate higher levels of professionalism. It is important to note that legitimation is not a linear process. While there might be hierarchical elements in moving from pragmatic to moral and to cognitive legitimacy (Suchman, 1995), they are not discrete processes, but rather recursive ones. This is so even when gains at the pragmatic legitimacy level go against moral or cognitive legitimacy, which might be the case more often with hybrid organisations and hostile environments. Thus, the mechanism of re-investment in legitimacy should be constantly in place. Hybrid organisations have an inherent disadvantage in striving for cognitive legitimacy due to the multiple logics they span. When they operate in a hostile environment, the process would be even more arduous. Therefore, nurturing networks of trusted partners and supporters could be instrumental in moving up the spiral towards cognitive legitimacy.

CONCLUSION

The study examines the case of the CAM organisations' legitimation efforts, which are exacerbated by their hybrid form and a contested context in the Western world, where, paradoxically, demand for these services is growing. CAM organisations thrive in an environment in which the

institutional profile is hostile (Tang & Hull, 2012). At the normative level, CAM offers services in a substantially different cultural context where assumptions about health are rooted in biomedical practices. The health-care cognitive environment is intimidating to CAM due to perceived contradictions with the scientific method. Knowledge about CAM practices is not widespread. Additionally, CAM organisations tend to be very small, which makes access to resources, including legitimacy, even more difficult.

The study relies on founders/managers of CAM organisations as informants because it focuses on legitimating actions stemming from decision-makers' subjective interpretations in line with the strategic lens on legitimacy. These actions are discussed according to Suchman's (1995) legitimacy model. To build pragmatic legitimacy, CAM managers accentuate trust-building to create a stronger value proposition. Specifically, they choose a two-pronged approach to value creation—improving well-being solutions and educating the public about various CAM therapies. At the same time, by choosing a hybrid organisational form, they declare the market-based logic to be the vehicle of their moral legitimacy aspirations. Achieving economic sustainability, adopting professional standards, building their practice on the biomedicine clinic model and investing in marketing communications and partnerships are all examples of business decisions seeking market approval in line with the prevailing market-based logic conferring moral legitimacy. These findings indicate a recursive feedback mechanism between pragmatic and moral legitimacy that could potentially lead to cognitive legitimacy.

In sum, the legitimation process for hybrid organisations follows these steps: first, establish pragmatic legitimacy with the group of users directly benefiting from the offering through the delivery of services valued by customers; second, take advantage of the pragmatic legitimacy gains to consolidate the dual purpose of the enterprise and establish a foothold on the moral legitimacy dimension; third, use market validation to enhance moral legitimacy and develop some of the other aspects, such as human capital, and supportive stakeholder relationships; fourth, initiate a recursive feedback mechanism between moral and pragmatic legitimacy gains; and fifth, invest in marketing communications initiatives broadening the customer base and societal foothold as a pathway to cognitive legitimacy.

AUTHOR CONTRIBUTIONS

Marta Bicho: Conceptualization (equal); Formal analysis (lead); Funding acquisition (lead); Methodology (lead); Resources (Lead); Software (Lead); Writing – original draft (equal). **Ralitza Nikolaeva**: Conceptualization (equal); Validation (equal); Writing – original draft (equal); Writing – review & editing (lead). **Carmen Lages**: Data curation (supporting); Formal analysis (supporting); Validation (supporting); Writing – review & editing (supporting).

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CONFLICT OF INTEREST STATEMENT

None.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

ETHICS APPROVAL STATEMENT

Ethics approval was received from the Ethical Commission at the ISCTE-IUL, number 46/2019.

PATIENT CONSENT STATEMENT

Not applied.

PERMISSION TO REPRODUCE MATERIAL FROM OTHER SOURCES

Not applied.

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ENDNOTES

[1] We elaborate on the concept of Complementary and Alternative Medicine (CAM) in the Context section, but for the purposes of the study we use the CAM therapies legalised by Portuguese law—Acupuncture, Homeopathy, Osteopathy, Naturopathy, Phytotherapy, Chiropractic and Traditional Chinese Medicine.

[2] The British Secretary of State for Health, Jeremy Hunt, was called 'Minister of Magic' in the UK media (Cheng, 2012). Another exemplary quote attacks the UK Science Minister Greg Clark: 'Clark has not made obvious or public endorsements of homeopathy since 2007. But his appointment has drawn criticism online from those who maintain—along with the overwhelming peer-reviewed consensus—that homeopathy, or the practice of diluting medicine to the point of absurdity in order to inspire the body to heal itself, has zero grounding in medical science' (Huffington Post UK, 2014). The academic literature has noted extensively the derogatory attitudes toward CAM along with processes of subordination and marginalisation coming primarily from biomedicine (Brosnan et al., 2018). In particular, Lewis (2019) documents how CAM in Australia is portrayed as lucrative profiteering, illegitimate and pseudo-scientific nonsense unworthy of being taught at universities. Further, in a review of the terminology used in academic discourse of CAM therapies, the authors find that the predominant frame of reference is biomedical scientific methods even when the terminology implies integration rather than exclusion (Ng et al., 2016).

[3] We thank an anonymous reviewer for this observation.

[4] Clinics are the designation in Portugal for 'private health units that carry out prevention, diagnosis, medical treatment and rehabilitation, irrespective of the legal form and name adopted' (Ordinance n.º 136-B/2014, p. 3684-(15)). The designation Clinics can only be adopted if the practice is legal and is subject to compliance with safety and quality rules, published by the Directorate-General for Health, which issues a legal license to operate under the designation of 'Clinics'.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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