Chapter 7

CAM practitioners and the professionalisation process

A Canadian comparative case study

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Introduction

Attempts by complementary and alternative medicine (CAM) practitioners to achieve professional status are not new. What may be new, however, is the increasing number of different CAM practitioner groups seeking legitimate status as healthcare practitioners throughout the industrialised world. For example, in the province of Ontario, Canada, naturopathic practitioners, traditional Chinese medical practitioners, acupuncturists and homeopathic practitioners are all striving for professional status codified in state-sanctioned regulation (Wellman *et al.* 2001). In Britain, both osteopathic and chiropractic practitioners have recently been regulated, and the House of Lords Report recommends regulation for acupuncture and herbal medicine (Select Committee on Science and Technology 2000). And in the USA, chiropractors, naturopathic practitioners and acupuncturists are being regulated in an increasing number of states. The professionalisation of CAM practitioner groups appears to be a widespread phenomenon, yet relatively little is known about how these practitioner groups are making the transition from occupation to profession.

The difficulties of defining the term 'profession' and the myriad definitions that have been proposed led Freidson to suggest that researchers clarify what they mean when discussing professions and the professionalisation process (Freidson 1983). For the purposes of our analysis, we are defining the gaining of statutory self-regulation or state-sanctioned professionalisation as being equivalent to the professionalisation process. The three CAM occupations we explore in this chapter are focused on the goal of state-sanctioned regulation and are at various stages in reaching it. Much of the discussion of professionalisation in the practitioner focus groups described in this chapter concentrated on what would happen when they gained this legal status, what the barriers were to achieving this status, and who their allies and competitors were in the pursuit of it. Statutory self-regulation was a central theme in all our focus groups.

Much of the research in the area of professionalisation focuses on conflicts over jurisdictional claims, quests for state-sanctioned self-regulation, and attempts at social closure. The vast majority of studies of professionalisation explore the pure professions (medical doctors and lawyers) and the professionalisation attempts of female-dominated ‘semi’ professions such as nurses and midwives. Since the 1990s, researchers of CAM have increasingly used professionalisation theories to understand what is happening with CAM practitioners (Saks 1995; Cant and Sharma 1996). We build on these studies by examining the relevance of two important concepts in the study of professions: social closure (Collins 1990; Saks 1995) and jurisdictional boundaries (Abbott 1988). Although social closure has received a fair amount of attention in recent analyses of CAM, Abbott's work on jurisdictional boundaries and the system of professions has been less prominent.

We take as the starting point for our case study the views of practitioners from three CAM groups in Ontario, Canada: naturopathic practitioners, homeopaths and traditional Chinese medicine/acupuncture practitioners. By focusing on the experiences of the practitioners themselves, we move away from a focus on what the leaders of the CAM associations say they are doing and the 'party line' that often supports these strategies. What our analysis offers is an examination of the challenges CAM practitioners believe they face as their group strives for statutory self-regulation.

The professionalisation process

Researchers who study the professionalisation process have a range of theories to choose from when seeking to explain the strategies employed by various occupational groups. One well-known approach, trait theory, looks at specific characteristics needed by an occupation to professionalise. Another approach to examining CAM occupations may be to incorporate issues of power, monopoly and complex interactions within CAM groups, between CAM groups, as well as between CAM groups and the other medical professions. To gain a better understanding of the latter approach, we utilise two perspectives from the study of professions: social closure (for example Collins 1990) and the system of professions (Abbott 1988).

Social closure explains part of the success some groups have had in working toward professional status. This concept

> refers to the process by which occupational groups are able to regulate market conditions in their favour in face of competition from outsiders by limiting access to a restricted group of eligibles, enabling them effectively to monopolize available opportunities.
>
> (Saks 1998: 176)

Certain healthcare groups, such as medicine and dentistry, have been masters at social closure. They have been able to exclude others from gaining jurisdictional control or statutory self-regulation. For modern professions, statutory self-regulation or state licensure is a primary way to achieve market closure. Whether the CAM occupations in our analysis will attain state-sanctioned regulated status is an important part of our question.[1]

The concept of social closure helps us to understand part of the picture of the professionalisation of CAM groups. But, as noted by others, social closure approaches do not fully account for the interactions amongst professional groups nor for processes other than exclusion in determining who gains control (Adams 1998). This is where the work of Andrew Abbott may be helpful for rounding out our understanding of the professionalisation of CAM groups.

Abbott's work highlights how professions are organised into a system, and he argues that it is more useful to analyse this system rather than analyse individual professions in isolation (Abbott 1988). A system approach regards the jurisdictional claims professions make as they assert their authority and/or try to gain status as being linked to the claims of other groups in the system. Abbott discusses the social, structural and cultural dimensions of jurisdictional claims made by professions. Professions may ask for 'absolute monopoly of practice and of public payments, rights of self discipline and of unconstrained employment, control of professional training, of recruitment, and of licensing, to mention only a few' (Abbott 1988: 59).

Claims may be made to the media, the legal system or the political system. For Abbott, it is not the content of the claims that is important, but the location, form and 'the social structure of the claiming professions themselves' (Abbot 1998: 59) that is of most interest. Abbott also argues that, as opposed to the trait approach to professions, 'a profession is not prevented from founding a national association because another has one. It can create schools, journals, and ethics codes at will. But it cannot occupy a jurisdiction without either finding it vacant or fighting for it' (Abbott 1988: 86). Following this reasoning, we see that the conventional medical establishment cannot stop the CAM occupations from organising and founding their own schools and associations. But it is the contests over jurisdiction, that is, where CAM practitioner groups will find space for their claims, that ultimately will determine the relative success of the various CAM professionalisation projects (Abbott 1988).

Abbott also notes that legally determined jurisdictions for professions tend to rigidly define what it is the profession does. He states 'Boundary areas are firmly delineated with formal definitions that are in fact uninterpretable in actual situations' (Abbott 1988: 63-4). Herein lies, in part, the rationale for examining the views of practitioners about the

professionalisation process. It is the practitioners, in the course of their actual work, that choose to work within (or outside) the boundaries as defined by their professional associations and/or government statutes. The ambiguities between how the practitioners view their work, as compared to the official goals of their practitioner group, constitute a key point for investigation of the professionalisation process.

Most studies of the professionalisation process have focused on the formal views of leaders. Here, we take a different approach, asking practitioners themselves about their work and their views concerning the professionalisation of their occupations and thereby examining the micro-level dimensions of professionalisation. Although we are looking at three distinct CAM occupations, and not necessarily the overlap between them, we see these occupations as making jurisdictional claims within much the same territory: first, the territory already claimed by mainstream medicine in general and, second, the territory of clients looking for alternatives (or complements) to mainstream medicine.

Case study: naturopaths, homeopaths and traditional Chinese medicine/acupuncture practitioners in Ontario, Canada

Methods

Three focus groups (one with practitioners from each occupation of interest) were held in Toronto, Ontario, Canada. Participants were randomly sampled from lists of practitioners obtained from the various practitioner associations. The lists were supplemented by names of practitioners obtained from other sources such as internet listings, advertisements in local health magazines and personal contacts. Every effort was made to ensure that the lists were complete before the sample was drawn. Selected practitioners were mailed or faxed a letter of introduction, followed by a telephone call from a team member to determine their availability and willingness to attend the focus group at the scheduled rime. In addition, to meet the inclusion criteria, they were required to be eighteen years of age or older, be actively involved in treating patients a minimum of twenty hours per week and be able to communicate in English well enough to provide informed consent and participate in a group discussion.[2]

Each focus group was led by a moderator who guided the group through a series of topics for discussion. The moderator began by posing general and broad questions to each focus group including: 'Are you aware of any professionalisation or attempts to be regulated going on for your occupation?' 'Do you think professionalisation or regulation is a good idea? Why, or why not?' Additional probes were used as needed. Another investigator also attended each focus group in order to compare field notes and discuss

the group process. Each two-hour session was audiotaped and transcribed verbatim.

The transcripts of each focus group were coded independently by four investigators using a constant comparative analysis (Berg 1989). The central issues that emerged in each group were identified through the key concepts or phrases used by participants during the discussion. After every focus group, the four investigators met to compare and combine their independent analyses. Such simultaneous data collection and analysis made it possible to explore and expand on themes from earlier focus groups at subsequent sessions. During the next phase of the analysis the investigators identified similarities, contrasts and potential connections among the concepts within and amongst each focus group. The final step in the analysis involved the development of the major themes and the identification of phrases or quotations that most accurately illustrated these themes. The software program QSR Nvivo (2001) was used to organise and code the data on the relevant themes.

Findings

The participants

The naturopathic focus group comprised five naturopathic practitioners, all educated at the same Naturopathic College in Toronto. Four out of the five were members of the same two naturopathic associations. The other individual did not list membership in any associations. Participants had been practising for an average of three and a half years. Four were women and three were born in Canada. The average age of the focus group participants was thirty-nine years. All participants were contacted as part of a random sample of naturopaths.

There were five participants in the traditional Chinese medicine (TCM)/acupuncture focus group. Four received their training in China (one of these four also received conventional medical training from a Canadian medical school). The fifth participant received training in acupuncture from an association that provides acupuncture training to primarily Western-oriented medical doctors. Two participants were members of a Western-oriented acupuncture association, two were members of one of the Canadian TCM-based associations, and one was a member of a different Canadian TCM-based association. Participants had been practising TCM/acupuncture for an average of twelve and a half years. Three participants were male and two were female. None of the participants were born in Canada, with four of them listing China as their country of origin. The average age of the participants was fifty-three years. Two of the participants were contacted as part of the random sample, while three were contacted through personal networks.

Ten homeopaths participated in the homeopathic focus group. Six were trained at the same college in Ontario, the other four were trained at different colleges, including one in the UK. Participants listed themselves as members of five different professional associations, with five of the ten informants belonging to the same Ontario homeopathic association. The participants reported being in practice for an average of five and a half years. Four participants were male and six were female. Four of the homeopaths were born in Canada; the other six were born in Eastern Europe, the UK or India. The average age of participants was forty-four years. Seven participants were contacted as part of the random sample while three were contacted through personal networks.

Key themes

Statutory self-regulation was clearly identified as the goal of the professionalisation process by the CAM practitioners in our focus groups. All the practitioners asserted that their CAM group was pursuing statutory self-regulation under the Regulated Health Professions Act (the Act under which all healthcare practitioners in Ontario are currently regulated). Most but not all, personally felt this was an important goal for their occupational group. The other three key issues that emerged from the focus group discussions were: the struggle to effect social closure; the challenge of lack of cohesion and jurisdictional battles within the individual practitioner groups; and the question of whether their work should be considered a profession or a single-practice modality. These are discussed in detail below.

SOCIAL CLOSURE

A long list of reasons for seeking statutory regulation was identified in all the focus groups. Many of these related to the groups' attempts at social closure. For example, all three practitioner groups expressed the opinion that statutory regulation would result in some form of monopoly with respect to the therapies they practice:

> Homeopathy is also the stepchild of each and every profession in North America. If you are a chiropractor you practice homeopathy along with it. If you're a naturopath, homeopathy is used in your practice. If you are a massage therapist... if you are a midwife, you use homeopathy and you can count not one, but twenty other areas . . . some kind of regulation will clear this area of various part-rime professionals.
>
> (Homeopathy focus group)

> The impression I get is that if you're in the newer Act you have a little more security and, as well. . . have more of a monopoly which unfortu-

> nately is the essence of the profession. That you need to be able to say, look I can do this and proportionally you can't and we have the legal whatever . . . recourse at our disposal to make sure that no one else can come in as a whatever . . . naturopathic impersonator and take over what we're doing because we've been trained under a certain statute or whatever.
>
> (Naturopathy focus group)

The groups tended to see regulation as a means to prevent the co-optation of their skills and knowledge by other professional groups:

> I think we have a window of opportunity to come together and try to pursue some sort of regulation because if we don't what's going to happen in the future is that some other profession will dilute homeopathy, perhaps medical doctors or specialists.
>
> (Homeopathy focus group)

> Unless you establish yourself with a college, with a piece of paper, what your stages are, who should enter the program, what the program is going to be, and who will regulate the program, then you only become a section of a recognized medical discipline.
>
> (Acupuncture focus group)

> But the thing is if we do get recognition in HPRAC; [Health Professions Regulatory Advisory Council] then we can say look to the OMA [the Ontario Medical Association] . . . you know, you actually have restrictions. You cannot be practicing this stuff; this is our scope of practice. You do not have experience with whatever it may be and, you know, please desist or otherwise we'll have to take legal action. So, you can put some pressure on other groups that are doing what we do, whether it's homeopathy or whatever. So, I think it still would help us from my perspective.
>
> (Naturopathy focus group)

Co-optation is the process by which one group embraces within their scope of practice techniques or treatments that were originally developed by or solely practised by another group. Physicians have been accused by many CAM groups of 'CAM-poaching' - incorporating the 'best' or 'scientifically proven' CAM treatments within the jurisdiction of medicine in a bid to eliminate the need for CAM practitioners. Co-optation was a real fear that was compounded by the real or perceived overlap between what each group claimed as their own jurisdiction or 'work'. Homeopaths, the least cohesive of the groups, appeared most worried about jurisdictional overlap with their fellow CAM practitioners, the naturopathic practitioners. For

their part, naturopaths and TCM/acupuncture practitioners were most concerned about already regulated medical professions:

> I think with the naturopaths we're really not sure whether we should be paranoid or embrace them because we're not sure whether they will swallow us up or not.
>
> (Homeopathy focus group)

> Competitors? I personally see the regular professions practicing acupuncture as competitors, for example, massage therapists.
>
> (Acupuncture focus group)

Added to these general competition concerns were concerns about claiming jurisdiction based on judgments about who was best trained to provide specific types of CAM care:

> I tend to agree that MDs pose the greatest threat in the sense that they subsume a naturopathic approach, albeit in 5 minutes.
>
> (Naturopathy focus group)

> I mean the naturopaths study approximately 200 hours in the entire four years of homeopathy and then a lot of them use it as a namesake because it is the one connection in all the modalities.
>
> (Homeopathy focus group)

Most practitioners felt that regulation would allow them to achieve a measure of social closure by instituting education and qualification standards that would prevent others from practising on their turf:

> I think if it's regulated there will be certain restrictions and people won't be allowed to practice that don't have the proper background or they will have to re-educate.
>
> (Homeopathy focus group)

> . . . that [regulation] to me from my perspective is a good thing because it will ensure that the quality of education is maintained at a certain level and even improved . . .
>
> (Naturopathy focus group)

> We must have a set of regulations so everyone can meet the regulations, before they can practice.
>
> (Acupuncture focus group)

LACK OFCOHESION AND INTERNAL JURISDICTIONAL BATTLES

One of the key challenges facing the groups' attempts at social closure is the lack of internal cohesion within the practitioner groups themselves:

> It's really important though that the community try to come together instead of breaking off into factions because we're not powerful to the government when we're all broken up into small groups. We need to come together as one large cohesive group and that's the only way. I mean I think the government likes it this way because it's easy to deal with us this way. It's much harder if we come together and are one large powerful group.
>
> (Homeopathy focus group)

> I don't understand why we're just so scattered . . . why we're not just a unifying strong group.
>
> (Naturopathy focus group)

Social closure strategies such as setting educational or practice standards can only be effective if the group can agree on the content and form of those standards. All the practitioner groups identified this as a challenge facing their group; however, it appears to be particularly problematic for the homeopaths and the TCM/acupuncture practitioners, who have a wide variety of training institutions and associations struggling for control of the profession in Ontario:

> What we haven't been able to do in 200 years is get along.
>
> (Homeopathy focus group)

> I think one of the barriers is the homeopathic community itself with their different opinions of regulation, as well as their different opinions on standards. ... So, we can't actually agree on anything as a group.
>
> (Homeopathy focus group)

> How many nuclei have started, right? [laughter] That is the problem, right?
>
> (Acupuncture focus group)

Some of the fragmentation that is evident within the practitioner groups is a result of diverse practice styles and philosophies. Establishing standards is exceedingly difficult because the practitioners who are attempting to professionalise actually practise different forms of each modality. Emerging from the homeopathic and TCM/acupuncture focus groups was the need to

determine who would 'win' the internal jurisdictional battles before statutory self-regulation could occur:

> I'm not speaking for anyone else in the room because I don't know any of these folks, but I have seen a lot of anger be directed at the kind of homeopathy that I include in my practice. It's not the only thing I do, but it is part of what I do and so there are some ways in which bringing the groups together can be very difficult and particularly people who feel strongly about regulation also tend, not always, but tend to feel strongly about the right way to practice. So, if you've got two groups who both feel strongly about the right way to practice, but the two groups don't agree, it means bringing them together is very difficult.
>
> (Homeopathy focus group)

> The only thing we have in common is the Law of Similars, that's it. Other than that, we practice differently. So, strong feelings are going to come because somebody is going to be accused of suppression or whatever else.
>
> (Homeopathy focus group)

> I see lots of conflicts in the group. One is standards: we don't want those who don't know acupuncture to practice acupuncture; we don't want those who don't know traditional Chinese Medicine to practice it ...
>
> (Acupuncture focus group)

Some practitioners feared a loss of freedom to practise as they wished if their practitioner group was regulated:

> I agree with you to a certain extent, if you're saying the use of the Chinese model. But what about Korean acupuncture? In Korean acupuncture, the diagnosis is a bit different, so they have another mode of medicine. If they say acupuncture belongs to Chinese medicine only, that means you exclude other practitioners who practice other types of acupuncture.
>
> (Acupuncture focus group)

> I would say wonderful if that were the case, but history teaches us when you bring in regulation, you also bring in restriction and that's not reality, as much as we would all around this table like to say how nice that would be. I mean I fully agree with you, it would be wonderful if we could regulate and be completely open and we're only talking about minimum standards of education and some basic surrounding knowledge ... it would be really nice to have that kind of surrounding

> set of standards, but historically ... I mean look at the massage therapists. Of all the schools, surely massage would be the most flexible, but if you're not Swedish massage, you're not an RMT.
>
> (Registered massage therapist)

> So, if you practice shiatsu and get 22:00 hours in training in anatomy and physiology and massage, you can not call yourself an RMT. So, the Swedish massage people are saying this is the only real way of doing massage and we know that's nonsense, but that's what is most likely to happen if we regulate.
>
> (Homeopathy focus group)

PROFESSION VS. MODALITY

Another issue raised by both the homeopathic practitioners and the TCM/acupuncture practitioners was the confusion over whether the therapy they practised was a profession in its own right or was simply a modality that could be employed by a variety of healthcare professionals. Currently, homeopathy and acupuncture are seen as both professions and modalities, which makes regulation of these practices exceedingly challenging. For the TCM/acupuncture group this issue was particularly acute. The week before the focus group, the Health Professions Regulatory Advisory Council (HPRAC)[3] released their recommendations about the future regulation of TCM and acupuncture in Ontario. In their recommendations, the HPRAC stated that they will consider acupuncture a modality, not a profession (Health Professions Regulatory Advisory Council 2001b).

> I am a bit confused about the whole situation. It sounds like there is a proposal that acupuncture is a treatment modality and that TCM is TCM. I don't know why we have to argue that acupuncture is a Chinese thing. Acupuncture, since 1973, has been known to the West, specially in North America and a lot of things have been developed since then. . . . To me, acupuncture is a form of physical therapy just like giving an injection. In traditional Chinese medicine, when you practice acupuncture, you also use injections of whatever substance, and there are schools in North America using similar techniques but they developed differently from different roots than acupuncture, so, I must say, that acupuncture treatment, I cannot agree with you that it belongs to Chinese medicine.
>
> (Acupuncture focus group)

> I agree that acupuncture can be viewed as a modality, but there is a line you have to draw. I can stretch this to an extreme ... in the gynecology department, the nurse might use one needle to induce labour ... so

> everyone can practice acupuncture because the applications are very high. However, for this you don't define acupuncture as a profession, but as a treatment of modality that can be used by a variety of professions. And as for regulation, it is just technique. ... If the professionalisation of radiation therapist or radiologist are being proposed by this report, the analogy can be drawn that radiation therapy can be treated as a modality. It can be prescribed and utilised by a nurse, if they were only trained for, say, a month, for just one type of breast cancer, then to prescribe one particular drug. . . . This is the analogy. Is there anything wrong? To some patients there might not be anything wrong, but to the bottom line that it defines a profession as basically a territory of practice . . . why can't a person trained for thirty days prescribe something a little bit more than Tylenol? ... It doesn't work that way because of the need of the professions.
>
> (Acupuncture focus group)

This highlights the fact that the CAM practitioner groups are trying to carve out 'turf in a healthcare system already overflowing with professions. They appear to realise that they need to find a place to 'fit' within the system (as opposed to the current situation where they operate outside the system):

> I think that one of the goals of us as a profession is to be more integrated into the health consciousness of Ontario, Canada; to be integrated into the health system and part of that is looking professional in the eyes of conventional medicine and the peers in that field so that that transition runs smoothly . . . that they will accept us more readily if we have the qualifications, the professional demeanor and what not. I think that's another reason to head towards regulation, towards this process of professionalisation.
>
> (Homeopathy focus group)

One of the biggest allies for all the CAM practitioner groups who are attempting to find their place within the healthcare system is the public:

> I think that the one thing which is happening is the pressure from the public because there are more people who are seeking the naturopathic services and I think it has changed in the last five years. This is one group of informed public who is helpful to our profession.
>
> (Naturopathy focus group)

> Other allies are the communities of people. In Toronto we have communities of people whose first medicine is homeopathy and if it doesn't work, then it is allopathy. One of them is the Muslim community, they have a spiritual homeopath and they have a weekly session on TV on

> homeopathy. They provide a centre of service from England as to what to take on what health condition people send them. So that's one big group in and around Toronto. I don't know the number. Then you have an East Indian community. Many of them will use homeopathy first.
>
> (Homeopathy focus group)

There is evidence that the groups feel a need to change (their rhetoric if not their practice) to fit into the current healthcare system. For example, the homeopaths (and the naturopathic practitioners) have recast their 'work' as possibly harmful (as opposed to the view previously popularised that CAM is perfectly safe). This is in response to the Ontario criterion requiring that a practice must have potential for harm before it is eligible to be regulated:[4]

> I also know that there are a few obstacles, one of which that the prime directive of the college network in Ontario is you have to first prove you're dangerous, which is easier to do with acupuncture and naturopathy and chiropractic medicine than it is with homeopathy.
>
> (Homeopathy focus group)

Discussion

Our data indicate that many of the key issues associated with the professionalisation of health occupations - the quest for state-sanctioned self-regulation, attempts at social closure and conflicts over jurisdictional claims - are clearly relevant for the professionalisation of CAM practitioner groups. Statutory self-regulation is the ultimate 'prize' coveted by all the practitioner groups, despite the fact that it may not be a goal for all individual practitioners. Overall, the groups expect that regulation will provide the necessary power to effect social closure around their 'turf. However, their efforts to gain social closure are hampered by a variety of barriers, including lack of internal cohesion, battles of jurisdiction and the need to fit into a healthcare system with no obvious need for additional professions.

The fragmentation within each occupation - as is particularly evident for the homeopathic and TCM/acupuncture communities - appears to be the single biggest obstacle for the groups to effect social closure. However, another key obstacle is what Abbott would term the lack of 'vacancies' in the current system of professions (Abbott 1988). There are already twenty-four health professions regulated in the province of Ontario (O'Reilly 2000), and there are no obvious gaps waiting to be filled by CAM practitioners. It appears that CAM practitioners currently perform some of the 'dirty work' in the system by specialising in treating difficult or undesirable patients, such as those with elusive complaints that have not been helped

by conventional care and those that are dissatisfied with the conventional system. In this way, CAM practitioners may be attempting to carve out a specific jurisdiction within the system and thus their patients may be their greatest allies when arguing the need for formal regulation.

The situation is complicated further by the social context of the regulated healthcare professions in Ontario, Canada. The legislative review process, begun in the 1980s and culminating in the 1991 Regulated Health Professions Act, had the goal of 'increasing the coordination and cooperation of the health professionals' (O'Reilly 2000: 199). The new Act includes a description of each regulated profession's scope of practice that provides 'information about what the profession does, the methods it uses, and the purpose for which it does these things' (O'Reilly 2000: 83), but is not meant to outline exclusive practice territories. Rather than licensing practitioners per se, the Act focuses on licensing specific acts or procedures that are deemed potentially harmful. These 'controlled' or 'authorised' acts can legally be performed only by specific professional groups authorised by the statute to perform them. Within this context, any attempts by CAM practitioner groups to effect social closure around a specific jurisdiction are made more difficult.

The situation has recently become even more challenging for the TCM/acupuncture community. The recommendation by HPRAC that acupuncture should be regulated as a modality, not a profession (Health Professions Regulatory Advisory Council 2001b), is problematic for gaining social closure and a full jurisdictional claim by one group that establishes their 'complete legally established control' (Saks 1998: 71). The report recommends that the government of Ontario establish a system of limited jurisdictional control of acupuncture for several professions, including doctors, nurses, TCM practitioners and physiotherapists.

This highlights the need for the CAM practitioner groups to find a way to 'fit' into the existing system of professions. The history of chiropractors in Ontario[5] suggests that CAM practitioner groups may need to accommodate their practice (and perhaps their philosophy of care) to fit into the conventional healthcare system if they hope to attain their stated goal of statutory regulation (Biggs 1989, 1994; Boon 1996). HPRAC has identified nine criteria by which they judge who should be given professional status in Ontario, and each CAM group must provide a submission to this Council providing a justification of how they meet each criterion. This context provides the rules by which the CAM groups must play. What is not clear is how conforming to these requirements will ultimately affect the scope of practice of the CAM practitioners (and the work that they do) if they ultimately become regulated healthcare practitioners in Ontario. How 'alternative' will they remain? Our data provide a useful baseline for future research of these issues.

Our results highlight key areas for further research. It is important to note that we collected data from a very small group of participants that is likely not to be representative of CAM practitioners in Ontario or elsewhere. The aim of this qualitative study was to explore the range of experiences of CAM practitioners who are members of different groups at different stages in the professionalisation process. While our findings are not conclusive, they do provide sensitising concepts and building blocks for theory generation. Only future studies with larger samples across a number of CAM occupations can assess the generalisability of our findings.

Conclusions

Writing about the situation in the UK, Saks states that '[e]ven the professionalisation of alternative medicine may not be as challenging as first meets the eye' (Saks 1998: 185). In Ontario, even though the CAM practitioner groups continue to experience significant internal fragmentation, HPRAC has recommended that both naturopathic medicine and TCM/acupuncture be regulated and has provided some direction on how this should be accomplished[6] (Health Professions Regulatory Advisory Council 2001a; Health Professions Regulatory Advisory Council 2001b). On the surface at least, the government is no longer standing in the way of the regulation of CAM practitioner groups. However, the HPRAC reports emphasise that the CAM groups are responsible for setting educational and practice standards and, given the current divisions within the groups (especially TCM/acupuncture), this could prove difficult. Clearly, achieving internal cohesion is one of the key challenges facing CAM groups attempting to professionalise. Another important challenge is whether CAM practitioners can maintain their distinct philosophies of care and unique practices within the regulatory framework to be imposed upon them. Additional research in this area will be critical in order to enhance our understanding of the professionalisation process.

The Ontario, Canada context for CAM professions shows both the usefulness and limits of the social closure perspective. Some degree of social closure will occur when the goal of statutory self-regulation is achieved, but it will not create a monopoly for some of the therapies that the CAM groups practise, acupuncture in particular. Due to the way regulation is structured in Ontario, other medical professions will still have the right to include some types of CAM work in their practices. This is where an analysis that includes the complex system of professions is needed - in particular, where more attention to the work of Andrew Abbott may shed light on the continuing jurisdictional battles between CAM groups and between CAM and conventional medicine. Abbott's emphasis on how boundaries between professions are established at the workplace site, or

through the work practitioners do, may prove helpful for understanding the system of CAM and conventional medical professions (Abbott 1988). This is especially relevant, as CAM becomes more integrated in the health-care system, hospitals and multi-disciplinary medical clinics throughout the world.

The professionalisation of CAM groups is necessarily constrained by the healthcare and regulatory systems in which it is occurring; however, the key components of the process are likely to be similar. Studies comparing the professionalisation of CAM practitioners in different countries would greatly enhance our knowledge of this process. In addition, longitudinal studies investigating the professionalisation project over time will provide insight, especially with respect to assessing the extent to which CAM practitioner groups compromise their distinct identities for state-sanctioned legitimacy. This chapter makes a strong case that all future studies in this area must investigate the professionalisation of CAM within the context of the system of professions.

Notes

[1] Self-regulatory status, with some degree of social closure, does not guarantee cultural legitimacy: chiropractors are a good example of this. In other work, we examine the relationship between statutory self-regulation and cultural legitimacy. Because of the stress placed on statutory self-regulation by the practitioners in our focus group, we focus on that.

[2] The exclusion of non-English speakers may have had a bearing on our results, especially for the TCM/acupuncture group. This warrants further investigation.

[3] The Health Professions Regulatory Advisory Council (HPRAC) has a mandate to review issues related to the Regulated Health Professions Act (including requests from new occupations wishing to be regulated under the Act) that are referred to it by the Minister of Health, and to make recommendations to the Minister (O'Reilly 2000).

[4] The nine criteria used to determine who should be given professional status in Ontario are: (1) Relevance of the proposed self-regulating group to the Ministry of Health; (2) Risk of harm to the public; (3) Sufficiency of supervision; (4) Alternative regulatory mechanisms; (5) Body of knowledge; (6) Education requirements for entry to practice; (7) Ability to favour pubic interest; (8) Likelihood of compliance; and (9) Sufficiency of membership size and willingness to contribute (O'Reilly 2000).

[5] Chiropractors significantly narrowed their scope of practice during their bid for state-sanctioned self-regulation. This strategy, which was successful for them, is detailed in several recent dissertations, for example, Boon (1996: 290) and Biggs (1989).

[6] Homeopathy has not yet been formally referred for review by HPRAC by the Minister of Health and Long-term Care.

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