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Moving forward? Complementary and alternative practitioners seeking self-regulation

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Abstract Complementary and alternative medicine (CAM) occupations continue to struggle towards achieving professional status, especially in the form of statutory regulation. Many consider professional status a worthwhile goal for CAM occupations, yet it is a process fraught with tensions. In this paper we present in-depth interview data from the leaders of three CAM groups (naturopaths, traditional Chinese medicine practitioners acupuncturists, and homeopaths) in Ontario, Canada that demonstrate four main strategies used by these groups to professionalize. The strategies discussed are related to how the knowledge base of each group is organised and transmitted. These strategies include: improving educational standards, improving practice standards, engaging in peer-reviewed research and increasing group cohesion. At the core of these strategies is the demarcation of who is qualified to practice, and a signalling to 'outsiders', such as medicine and the government, that practitioners are qualified and legitimate. Across the three groups, the leaders referred to the inclusion of medical science as a basis for distinguishing between 'science' and 'non-science' as well as who should practice and who should not. We highlight how internal battles over the infusion of medical science into the knowledge base are part of the process for establishing legitimacy for the three CAM groups in our study. We end with a brief discussion of the implications of these internal battles over medical science knowledge for the future of CAM groups.

Keywords: professions, complementary and alternative medicine, boundary-work, Canada

Introduction

The pursuit of professional status has long been a goal of various occupational groups. Medical doctors and lawyers, in particular, have gone through an arduous process to carve out specialised niches for themselves under the umbrella of professionalization (Blishen 1991, Clarke 1990, Torrance 1987, Wilson 2001). More recently, other occupational groups such as chiropractors and midwives have vied for professional status. Professional status implies that a group has the required knowledge and expertise, as well as jurisdiction or exclusive control over the content of its work and the conditions under which its members practice (Friedson 1970). In order to secure autonomy and gain control, an occupation must be legitimated by both the public and government (Smith-Cunnien 1998).

The transition from occupation to profession has been conceptualised as the professionalization process (Abbott 1988, Cant and Sharma 1996, Saks 1995). Studies of the professionalization process focus on two aspects, 1) the establishment of 'professional dominance' whereby the state grants a 'quasi-monopoly' to the occupation, often through granting statutory regulation, and 2) the securing of 'consulting status' whereby the groups work to gain the support of and use of their services by the public (Friedson 1970, see also Pescosolido, Tuch and Martin 2001: 3). In this study we focus on the first aspect – achieving professional dominance. To do this, we examine the attempts of three complementary/alternative medicine (CAM) occupational groups (naturopaths, traditional Chinese medicine practitioners (TCM), acupuncturists and homeopaths) in the province of Ontario, Canada to establish professional dominance through statutory regulation. Although we acknowledge that gaining statutory regulation does not guarantee public acceptance or full professional status, the groups in our study are currently focused on this goal. By comparing these three CAM groups we are able to identify issues that are unique to each group as well as common to all.

In this paper, we argue that these CAM groups are using a variety of strategies, based on claims to knowledge of medical science, to demarcate which groups should receive statutory regulation. The CAM groups are attempting to create boundaries around who is considered a credible CAM practitioner with a valid knowledge base, versus those who are not. This paper highlights how battles over the infusion of medical science into the knowledge base are part of the process for establishing legitimacy (Cant and Sharma 1996). We base the rationale for our study on earlier work in the professions that shows the importance of boundary work for distinguishing the line between 'insiders' and 'deviant' or 'pseudo' members of a professional group (*e.g.* Gieryn 1983: 792, Norris 2001, Cant and Sharma 1996). We explicitly focus on the internal boundaries and extent of cohesion of CAM groups and how their internal boundary work involves debates over the inclusion of medical science. Although the relationships of CAM groups

to external groups such as doctors and government are key to their ability to gain professional dominance, we believe the internal battles are also key to understanding the success (or lack of success) of CAM groups. In the following section, we discuss our overall theoretical perspective for the study of CAM occupations and their efforts to professionalize.

Theoretical overview

Trait versus social closure: two perspectives on the professionalization process

Researchers who study the professionalization process have a range of theories to choose from when seeking explanations for the strategies employed by various occupational groups. One well known approach, for example, *trait* theory, looks at specific characteristics needed by an occupation to professionalize, such as having a code of ethics or training school (Caplow 1954, Wilensky 1964). These earlier analyses have been criticised by a number of scholars such as Freidson (1970), Johnson (1972), McKinlay and Arches (1985) and Saks (1983). They point out that the trait perspective obscures 'the social and historical conditions under which occupational groups become professions including the power struggles involved in the process of professionalization' (Saks 1983: 2). They also argue that these approaches have accepted without criticism the professions' own definition of professional practice and in doing so, have legitimated professional privilege.

Other studies of CAM occupations have shown the relevance of the neo-Weberian perspective of *social closure* (Collins 1990, Saks 2001). This perspective highlights the importance of power and portrays professionalization as a dynamic process that has historical and national roots (Saks 1983). 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 thus enabling them effectively to monopolize available opportunities' (Saks 2000: 224, see also Saks 2001, Parkin 1979). Professions use their credentials and an abstract knowledge base as the foundation for their arguments regarding the necessity for state-sanctioned monopolies.

Social closure explains part of the success some groups have had in working toward professional status. Certain health care groups, such as medicine and dentistry, have been masters at social closure; they have been able to exclude others from gaining jurisdictional control or state sanctioned self-regulation. For modern professions, regulation or state licensure is a primary way to achieve market closure. A number of CAM groups around the world are currently striving to achieve self-regulation and a degree of professional monopoly that comes with it (Saks 2001, Cohen 2002, Walker and Budd 2002, Boon 2002, Carlton and Bensoussan 2002).

The social closure perspective argues for a central emphasis on 'group self-interests and market-based rivalries' for understanding the establishment of 'occupational boundaries and hierarchies' (Saks 2001: 120). Social closure reflects the political nature of the marginalisation of CAM. What is key is how dominant groups such as medicine have the power to exclude CAM knowledge, often based on non-Western or holistic philosophies of care, from access to institutionalised research funding and mainstream undergraduate medical education (Saks 2001: 120). We follow in the social closure tradition by moving beyond simply outlining the traits and attributes needed to professionalize. Rather, we focus on how the possession of certain attributes '*justifies* professional status' (Cant and Sharma 1996: 580).

While social closure arguments focus most directly on the political process of professionalization, they also point to how the knowledge claims of occupations are used for determining their jurisdictional boundaries. To understand the professional project of the CAM groups and the way they influence the organisation of each group, we now turn to a discussion of the structure of these knowledge claims.

Boundary work and knowledge claims

One way to understand these internal boundaries is to examine the ways in which the CAM groups develop boundaries around their knowledge claims (see also Norris 2001). Often these battles are over which group within a CAM occupation has the most credible knowledge claim. For CAM, it seems that those factions that are able to position their knowledge claims in a way that can be seen as most compatible or aligned with the dominant knowledge claims of medicine have the greatest chance of gaining social closure.

Gieryn's account of the boundary work in the professional ideologies of scientists identifies how the demarcation between scientific and non-scientific may be 'a likely stylistic resource for ideologists of a profession or occupation' (1983: 791). In other words, some professional groups try to recast their work so that it is aligned with science. In this case, boundary work describes the 'attribution of selected characteristics to the institution of science (*i.e.* to its practitioners, methods, stock of knowledge, values and work organization) for purposes of constructing a social boundary that distinguishes some intellectual activities as "non-science"' (Gieryn 1983: 782).

Although Gieryn focuses on scientists' ideological efforts, his notion of boundary work is relevant for understanding how the various CAM professional projects distinguish their internal and external knowledge claims (*e.g.* Norris 2001). One of the ways that the rhetoric of science is useful is for the process of monopolising professional authority and resources: 'boundary-work excludes rivals from within by defining them as outsiders with labels such as "pseudo", "deviant", or "amateur"' (Gieryn 1983: 792). CAM groups frequently have faced boundary-work at the hands of the medical establishment. To varying degrees (and at varying times), Western medicine

has attempted to portray CAM as non-scientific quackery (*e.g.* Beyerstein 1997, O'Reilly 2000).

Cant and Sharma's (1996) analysis of British homeopaths shows how the organisation and transmission of the knowledge structure of CAM occupations is central to their professionalization project. Over time, medically and non-medically qualified homeopaths have tried to distinguish their knowledge from that of other healthcare providers. This has included altering the content of their knowledge, seeking external validation for their knowledge claims and creating accreditation mechanisms for their educational programmes. This process, though, is not without risk. As Cant and Sharma correctly point out, although the changes to British homeopath's knowledge structure are 'important for legitimation purposes, [the changes] carry the risk that patients may be alienated and homeopathy placed in a subordinate position to orthodox medicine' (1996: 579).

We use the demarcation of knowledge to understand the level of strategies pursued by the leaders of the three CAM groups in our study. On one level, these strategies are concerned with positioning the CAM group to gain state sanctioned self-regulation. On another, more conceptual level, these strategies are about using knowledge claims to demarcate the boundaries between good and bad practitioners within a CAM group, as well as to gain acceptance of their group from medicine, the government and the public. In our analysis we focus on how three CAM groups use knowledge claims of 'science' to exclude rivals from within. We also discuss how CAM groups use these claims to try to establish themselves externally as 'worthy' of state sanctioned self-regulation. Before we proceed with our analysis, we first outline the local context of the CAM groups in our study. We follow this with a discussion of our data and methods.

The Canadian scene

In the field of healthcare, self-regulation is granted by the state on the understanding that members of the profession possess a specialised body of esoteric knowledge which the government trusts them to use on behalf of their clients (Gilmour, Kelner and Wellman 2002, Beardwood 1999). When a group of healthcare providers becomes self-regulated, the government delegates to them the power to establish standards of practice and training, and to discipline their members for breaches of these standards (*York Report* 1999, Casey 1999)[1]. In the 1980s, the province of Ontario established a review commission whose purpose was to examine the regulation of all health disciplines in the province. The commission recommended that 23 professions be granted self-regulating status (Health Professions Legislation Review: *Striking a New Balance* 1989, O'Reilly 2000). These included several healthcare occupations that had been seeking to attain professional status, including chiropractors and midwives. The stated purpose of the new legislation

was to 'shift the emphasis from profession-centred regulation to public interest regulation and promote the provision of high quality professional care' (Health Professions Regulatory Advisory Council: *Adjusting the Balance* 2001, Foreword). In pursuing this goal, the government wished to move away from a monopolistic format and open the door to some formerly excluded groups of healthcare providers.

The push for self-regulation is occurring at a time when consumers' deference to physicians is diminishing (Haug and Lavin 1983, Coburn 1993, Starr 1982), physicians are losing some autonomy to the state (Coburn 1993), and governments are expected to ensure that the health professions will be accountable to the public (O'Reilly 2000). At the same time, the three CAM groups examined here are experiencing the greatest rise in their popularity in the 20th century. Some form of CAM is used by over half of the Canadian population each year (Angus Reid 1998, Berger 1999). In addition, there has been a corresponding growth in the numbers of CAM practitioners. Their educational institutions are thriving and graduating increasing numbers of students each year (Newsletter, Canadian College of Naturopathic Medicine 2000). There has also been a substantial rise in the number of studies on the efficacy of CAM therapies published in peer-reviewed scientific journals such as the *Journal of Alternative and Complementary Medicine*, *Complementary Therapies in Medicine* and *Focus on Alternative and Complementary Therapies*. Established health professionals are showing an increased interest in these practices, at least partly because of the high rates of use among their patients (Verhoef and Sutherland 1995). Medical schools are beginning to include knowledge of CAM in their curricula (Ruedy, Kaufman, and MacLeod 1999, Verhoef, Best and Boon 2002). This is all happening at a time when provincial governments are in the process of restructuring the healthcare system to contain costs, while at the same time, individual consumers are attempting to maximise their choices for care (Coburn 1999).

Explanations for the growing interest in professionalization among many CAM practitioners include a desire to gain greater legitimacy for the therapies concerned, as well as a wish to realise positive benefits for themselves such as enhanced income, status and power (Sharma 1995). Not all CAM groups are at the same stage in the professionalization process. Those practitioners who are less enthusiastic are concerned that their group may have to pay for enhanced status by limiting its scope of practice, as happened in the case of chiropractors (Biggs 1989, Smith-Cunnien 1998).

The three CAM groups studied here have been developing a range of strategies they hope will result in a recommendation for statutory self-regulation and will ultimately bring them full professional status. Here we analyse the commonalities and differences between the three groups. This kind of comparative analysis has not previously been performed in the field of complementary and alternative medicine. It allows us to identify issues that are unique to each group as well as those that are common to all.

Methods

We derived the data for this analysis from personal interviews with all the senior leaders of the major schools and associations connected to the three CAM groups in the province of Ontario in Canada. Leaders were identified by their organisational positions and by reputation. The interviews consisted of a combination of closed and open-ended questions. We interviewed nine naturopathic leaders, seven homeopathic leaders and eight TCM/acupuncture leaders. In these hour-long, semi-structured interviews we asked the leaders to describe the steps each group was undertaking to professionalize, and in particular, to reach the goal of self-regulation. We asked what they thought about the advantages and disadvantages of becoming a profession and about their perceptions of the pressure to prove the efficacy, safety and cost-effectiveness of their therapies. The interviews were audio taped and transcribed verbatim. All the leaders we approached granted us an interview, thus ensuring a complete picture of the range of viewpoints on professionalization.

In order to capture the depth and detail of the leaders' aspirations, we analysed their responses using qualitative methods (Morse 1992). All transcriptions were entered into a qualitative software programme (Nvivo) for coding and analysis. Constructs and concepts were extracted from each interview independently by at least three investigators. Consensus on key concepts was achieved during team meetings. We then examined similarities and differences across CAM groups. Lastly, we identified underlying themes and categories to organise the data and permit comparison between the three groups (Denzin and Lincoln 1994, Bernard 2000). Through a process of comparing and contrasting, we refined the underlying themes.

Findings

Our analysis concentrates on four strategies that the leaders of the CAM groups said they were pursuing to help them reach their goal of state-sanctioned self-regulation. The strategies discussed are related to how the knowledge base of each group is organised and transmitted. These strategies included improving educational standards, improving practice standards, engaging in peer-reviewed research and increasing group cohesion. At the core of these strategies is the demarcation of who is qualified to practice, and a signalling to 'outsiders', such as medicine and the government, that practitioners are qualified and legitimate. Across the three groups, the leaders referred to the inclusion of medical science as a basis for distinguishing between 'science' and 'non-science' and who should practice and who should not.

While these three sets of leaders shared the common goal of gaining state-sanctioned self-regulation, they varied in the emphasis they placed on these

four strategies. Their differences reflect the different histories, characteristics and organisational structures of the groups the leaders represent. We first discuss the context in which each group is operating and then move to an analysis of each group's position as it compares with the other two.

The context

Naturopathy

While the naturopaths were regulated in Ontario in 1925 under the *Drugless Practitioner's Act*, this severely restricted the claims they could make, as well as their scope of practice. The consequence was to relegate them to a subordinate status in the healthcare field (Blishen 1991). Until well into the 1970s, they remained a small disparate group. During the past two decades, they worked to build a comprehensive organisational structure that has allowed them to mobilise resources and membership. Recent estimates indicate that there are around 270 active practitioners in the province (Hough *et al.* 2001). They now have a national organisation and provincial associations in seven of the 12 provinces. The primary educational institution in the country is located in Ontario (The Canadian College of Naturopathic Medicine). It has experienced outstanding growth, graduating over one hundred students in the past year. It is this institution that currently exerts most of the leadership for the naturopathic group; despite some recent progress, the provincial and national associations still take a secondary role.

While naturopaths are agreed on the desirability of self-regulation, there appear to be some significant conflicts among them. Issues such as how quickly they should grow, how best to publicise what they do, how much emphasis there should be on science in their education, and the way to bring about integration with the larger healthcare system are all contentious and unresolved. The naturopathic leaders expect that agreement among the group will increase as the new, better-educated and more numerous graduates begin to assume posts of leadership in the occupation's organisational structure.

TCM/Acupuncture

The TCM/acupuncture group is composed of a mixture of acupuncture specialists and TCM practitioners, as well as a combination of those who offer both therapies. In Ontario today, there is a proliferation of different kinds of training programmes and organisations in this specialism, each vying for power. When there are disagreements within a particular group, one of the parties often leaves to set up a new college or association. Communication among the various factions is thus limited and often acrimonious, making it difficult to present a united front to the public or to government power. While it is difficult to estimate the number of practitioners in the province because of the fragmentation of the group, it is our distinct impression that this group is smaller than the naturopaths. The leaders have been requesting

regulatory status from the Ontario government for nearly 20 years in submissions of various kinds.

Homeopathy

Although widely used in several other parts of the world, homeopathy has not flourished in Ontario, despite its earlier popularity in the last century (Crellin *et al.* 1997). To date, the homeopaths in Ontario have had little success in entering the arena of established health professionals (O'Reilly 2000). While they have made submissions to government for self-regulation, these submissions were unsolicited and have not received serious consideration. During the last decade, there has been a small-scale revival (O'Reilly 2000). There may be as many as one hundred practitioners in Ontario, although there is no central listing to confirm this estimate. Of the three groups discussed here, this is clearly the smallest. In 2001, the different colleges in the province graduated approximately 30 students (Plotkina Personal Communication, 21 September 2001).

Some students come to homeopathic training with a background in medicine from Europe or elsewhere, while others come directly from science courses at Canadian universities or high schools. There are several competing provincial homeopathic associations and a number of national associations and educational institutions. There are at least four homeopathic colleges in Ontario, each organised around a strong personality, and each in competition with the others. Although one homeopathic group has applied for regulation, the others have not taken an interest in it or do not consider it an advisable step at present. There is no indication that the various groups are trying to co-operate on this issue, much less collaborate.

The strategies

Having described the context in which the three groups are currently operating, we now turn to a discussion of the strategies the leaders are contemplating in their efforts to gain self-regulation on the path to professional status. As we argue, underlying their ability to use these strategies successfully are specific attempts to demarcate knowledge-claims from internal competitors. In particular, all groups engage in internal boundary work that involves the infusion of medical science into their education, practice and other activities.

Improving the quality of education

The naturopathic leaders give high priority to a strategy of improving the quality of their educational curriculum. The naturopathic college is committed to developing a rigorous and scientific programme and student enrollment is rapidly expanding. Recently, a naturopathic education council in the United States granted accreditation to the college in Ontario. One leader told us:

> It is really important to establish the credentials, the accreditation and the standards that go with the college in order for it [naturopathy] to gain acceptance. I also think the college has to have a much larger scientific base and we see that now with our new students.

Other leaders echoed this sentiment calling for an extensive scientific curriculum. A leader argued that the way for naturopathy to position itself to play a key role in the healthcare of Canadians was 'by graduating highly confident, compassionate doctors with a sophisticated scientific background and [who] will treat the whole body and the ongoing health of the individual'. Claims to science were used to designate the high-quality of the naturopathic education. With only the one college to concern them, the naturopaths are in a good position to carry out this plan.

The TCM/acupuncture leaders considered it very important to improve and standardise the quality of education for practitioners. They spoke of the need to establish high standards of training throughout North America, including continuing education. As one leader put it: 'We need to get with the times and set up a credible programme'. Although not outlining what a 'good' education was, another leader stated, 'If we had a few good colleges offering high standard professional training we would be in a much better situation [in terms of regulation]'.

Some leaders were convinced that the inclusion of anatomy, physiology and other medical sciences in the curriculum was necessary to ensure a modern education. One TCM/acupuncture leader mentioned that the education of future practitioners should include 'modern sciences and therapies, based on new research'. Another leader and teacher of acupuncture classes stated:

> I stopped teaching for them [another association] because they started to teach people who did not have a background in anatomy or physiology and if you don't know where the organ is, you don't know if you are going to puncture it. These things would be addressed with regulation [and] minimum standards of education.

The debate over educational standards for TCM/acupuncture, however, is not just about the inclusion of anatomy or a science-based curriculum. It also concerns whether any knowledge about Chinese medicine should be taught. The same leader that stopped teaching because of students' lack of anatomy and physiology also discussed how other acupuncture training organisations did not teach enough (or any) Chinese medicine: 'They [another acupuncture association] are trying to push their own acupuncture and only through our urging in [specific year] did they start teaching TCM in their courses'. Another TCM/acupuncture leader discussed the need for a comprehensive curriculum that included both allopathic and TCM-based courses:

> We have a curriculum which is broad in its scope and covers the fundamentals of making a traditional Chinese diagnosis and utilising traditional acupuncture but it also has an emphasis on an anatomically-based type of acupuncture that can be learned much easier [by those] who are pre-trained in medicine . . .

For some leaders, a good education should incorporate both TCM and allopathic understandings of medicine and anatomy. The problem with improving educational standards for TCM/acupuncture is that unlike naturopathy with its single college, there are many diverse educational institutions, each with its own version of what constitutes an acceptable curriculum. The various training programmes are far apart on the issue of which country has the best tradition of training. For some, the system that exists in China is seen as preferable, while for others, the best education is the one offered here in Ontario. Several different leaders believed that their own particular institution was taking a leadership role in creating uniform, high standards.

A number of the leaders were convinced that self-regulation would impose minimal standards of education for all their schools and looked forward to this happening. Yet there is much internal friction as to who should be able to claim the knowledge-base. Some leaders use claims to science and medical training to distinguish their educational standards as superior. At the same time, having TCM-based knowledge is used to demarcate 'true' acupuncturists from 'pseudo'-acupuncturists. It is these battles over the knowledge base that complicate the ability of TCM/acupuncturists to put this strategy in place.

Similarly, most of the homeopathic leaders believed that homeopathy would benefit by strengthening the quality of its educational institutions. They regarded turning out highly qualified, skilled practitioners as a key strategy in the struggle to become more professional. Some leaders saw a need for accreditation and certification and development of a more medical-science basis for their educational programmes. As one leader told us:

> We need to train people in science so that we can know exactly what our limits are. You have to know what the symptoms are. Even in chronic disease, you have to know what you can reverse and what you can't. That is why we need to train people in science.

One of the leaders discussed the need for older homeopaths to upgrade their training when wanting to join an association:

> Some of them were practising for years and years so it made it easier to assess them in terms of homeopathy, but they did not have the other part, the science standards which almost none of them, I think only one of them, were even close to our standards. You usually do give them about five years to upgrade their science, biology, biochemistry, anatomy, technology, all of the other science programmes . . .

For some homeopathic leaders, the boundary between high standards and low standards is marked by a curriculum that includes a substantial component of medical science versus a solely homeopathic curriculum. Homeopathic leaders justified their emphasis on medical science as the boundary between qualified and unqualified practitioners on the need to protect the public from harm. The following example illustrates why they believe this is crucial to their professionalization project:

> We [our organisation] have lectures here for the public every [certain day] of the month. [Name of instructor] was giving the lecture and there was this guy that comes to the lectures and he gives [the instructor] a card at the lecture and it says John Doe, Doctor of Homeopathy. And [the instructor] asked where he had gotten his education and he said, 'What do you mean, I came to your lectures'. And then tomorrow he will put up a shingle [sign] and say that I am a homeopath. Therefore regulation is vital . . . misdiagnosis could do a lot of harm. Misdiagnosis and a person who has no knowledge of medical sciences could miss the diagnosis and not refer the patient to a specialist.

Hindering the push for higher educational standards in homeopathy is competition between schools, with differing standards, training periods and tuition costs. While establishing higher educational standards was a strategy that most of the homeopathic leaders would like to pursue, there are serious differences among the training institutions regarding what constitutes an appropriate course of study. As in the case of the TCM/acupuncture group, the splintering of the homeopath's educational institutions means that the leaders will find it exceedingly difficult to follow this strategy.

Developing high standards of practice

Practice standards are clearly linked to the nature of a groups' educational programme. This was reflected in our discussions with the naturopathic leaders. Many of them expressed concern that some practising naturopaths are not properly trained and that this puts the safety of all naturopathic treatments in doubt. A number of leaders made it clear that they wanted to exclude those who were not properly trained and to do this, they had to enforce universal and high quality standards of practice. The unified organisational structure built by naturopathy makes it possible to pursue this strategy vigorously.

The TCM/acupuncture leaders were also strongly in favour of having high standards of practice that could be universally applied. Unfortunately, as with improving educational standards, the diversity of knowledge claims within this group seriously hampered their efforts in this regard. The many different associations have varying ideas about appropriate practice standards and each seemed convinced that their standards are the ones that all practitioners should follow. One leader told us:

> Guidelines for practice have to be set up, with different levels of professional standards; some for MDs with qualified acupuncture and TCM training, some for qualified acupuncture and TCM practitioners and some for non-qualified adjunct practitioners. At the present time, some people are not trained properly to practice.

The leaders were relying on self-regulatory status to ensure that adequate standards of practice will be established and followed. High standards were seen as important for protecting the public. Yet, each group believed it was *their* standards, based on *their* claims to superior knowledge, that were best. When discussing why some acupuncturists might be concerned about regulation, one leader stated:

> . . . there may be some health professionals who worry that regulation of TCM and Acupuncture may infringe their interest, since they practice Acupuncture according to their own standard, which is far below the recognised TCM standard.

This situation cannot be remedied, however, until the various factions can coalesce to enforce practice standards on their members. Like the other two groups, a majority of the homeopathic leaders considered it important to develop stricter practice standards for their discipline. One leader emphasised that:

> The first task is to get everyone out in the open and set some minimum standards. We hope to do more on standards so that they are equal to allopathic medicine.

Some of the leaders saw this step as a vital one for achieving regulation, with the protection of the public used as the rationale. The disagreements over educational standards were mirrored in the disagreements over practice standards. Those homeopaths without a medical background were viewed by some leaders as putting the public at risk. Unfortunately, there is no central body that can control the standards of practice for all homeopaths. As in the case of TCM/acupuncture, although a number of the leaders see the advantages of such a strategy, the divisions within the group preclude them from following it except in a piecemeal fashion.

Developing more peer-reviewed research

Peer-reviewed research that can demonstrate the efficacy and cost-effectiveness of naturopathy was mentioned by most of the leaders as a necessary tactic for achieving professional recognition. One leader argued:

> We have to better demonstrate our efficacy; do more studies so we can go to government and say, this is how we can be integrated into the healthcare system and save it money.

Naturopathic leaders pointed to the need for more clinical research as crucial to bolstering their claim for state-sanctioned self-regulation. A lot of the push for research stems from the desire of some naturopathic leaders to strengthen their position vis-a-vis medicine. As one leader stated in terms of the need for research:

> I think that is what the CMA [Canadian Medical Association] will use as one of their criticisms of the profession. The more work that is done in that area the better off everyone will be.

By engaging in certain types of research, naturopathy may be able to gain support and legitimacy from the mainstream medical profession. Not all the naturopathic leaders were enthusiastic about doing research; some said they were happy to rely on empirical evidence of patient successes and believed that there was already a lot of information available about the efficacy and safety of naturopathic care. As one leader said when asked about the need to prove the efficacy of naturopathic medicine:

> It depends on what you mean by prove. If it means that we need to have scientific studies then I think no, but to demonstrate the efficacy through . . . I don't think that we need to do double blind studies to prove the efficacy, however I do think that we need to have more clinical evidence and outcome studies and those are really important.

While almost all the leaders believed that in order to gain self-regulation their group will have to carry out peer-reviewed research, there was debate about the kind of research that needed to be done. Some leaders urged collaborative research with other health professionals, some believed that clinical trials were essential, and still others argued that new, more appropriate research methods were required adequately to assess the efficacy of naturopathy. There appears to be a significant difference between 'scientific studies' or 'RCTs' (randomised controlled trials) and observational or empirical evidence gathered from clinical practice[2]. Underlying this division is the argument or belief by some leaders that research methods appropriate for allopathic medical research are not appropriate for the holistic and individualistic orientation of naturopathic medicine. What is clear is that most of the naturopathic leaders regard encouraging and conducting research as a very important step in the professionalization process.

Although a couple of leaders of the TCM/acupuncture groups mentioned developing more high-quality research on efficacy as a strategy, the majority seemed to believe that there was already ample proof. As one TCM-based leader said: 'Its longevity has already proved its efficacy. It has been tested on millions, if not billions of people in the world and it is proven daily in my practice'.

Another TCM/acupuncture leader's comments illustrate the tension between scientific research and the existing proof for TCM, similar to that expressed by the naturopathic leaders:

> Science cannot understand it but it does not mean that it does not exist . . . I think that the proof of efficacy really depends on how you look at it. What is proof, five thousand years of proof is not accepted. Do you have to have scientific proof? The mainstream wants double blinded clinical trials to prove efficacy. Because TCM and acupuncture are highly individualised, how are you going to do a clinical trial?

One of the leaders was more circumspect about existing evidence. This leader commented that although the anecdotal evidence was overwhelming, it was not enough for some people:

> There will continue to be more and more evidence. People would never believe and then JAMA [Journal of the American Medical Association] publishes a study on it that you can really do that and then people have to sit up and notice.

Most leaders believed the efficacy of their modality had been proved by its history of use, but some of these leaders also acknowledged that it would take 'scientific evidence' to get TCM/acupuncture accepted as part of the mainstream medical system. The homeopathic leaders were split on the importance of building up a body of peer-reviewed research on efficacy and safety. A leader who felt strongly that research was needed argued that:

> We need to change the views of other healthcare practitioners but we need data. With data we can talk to physicians so that they will refer patients to us.

Another leader stated:

> I think we need a lot of research. This is absolutely vital for homeopathy because one of the biggest cards for our opponents is that there are not enough double blind studies done on homeopathy to prove its efficacy. We do have a lot of double blind studies but because homeopathy is a poor sister of allopathic medicine there is no money to have that research. This is vital.

This same leader, however, also pointed to the tension between scientific evidence and the homeopathic approach, questioning whether traditional medical science research could adequately capture the effect of homeopathic treatments:

> . . . in homeopathy there was a famous double blind study in *Lancet* . . . and homeopathy [was] 2.5 times more effective than placebos. If we are talking about placebo, this is only one very strong aspect of homeopathy that could be used as a placebo. If you talk to a person for an hour and a half compassionately, how do you measure that? It is priceless.

This tension partly underscores why about half of the homeopathic leaders believed research was not needed –- to them it was so obvious that homeopathy works. As one leader claimed: 'It is already proven all over the world. There is a 200-year history of successful case histories'. Clearly these leaders were concerned about the imposition of 'scientific' forms of proof and did not agree on the strategy of increasing peer-reviewed research on their therapies and practices.

Increasing group cohesion

The battles over educational standards, practice standards and peer-reviewed research point to the lack of internal unity among each of the CAM groups in our study. Although the naturopaths in Ontario are far better organised and more united than the other groups described here, the leaders still believed it necessary to encourage more cohesion. They told us that they had recently held a summit meeting aimed at forging a consistent vision for naturopathy and a unified approach to dealing with the government. A leader pointed out that naturopaths as a whole were far from unanimous about some of the policies the leaders were pursuing. At least two of the leaders referred to the need for naturopaths to start acting as team players:

> One of the biggest challenges is facing ourselves. There is no concept of the whole. People have to start respecting other people's opinions and toeing the party line.

Echoing the team player theme, another leader also emphasised the division between older and newer naturopaths:

> . . . I know the history is that there are naturopaths on their little islands doing their own little things. That is the biggest problem that we have is getting everyone to play as a team because there are so many people out there, especially those practising for 20 years or more, they had no support out there so they learned to keep a low profile . . . You cannot do it as an individual.

Another leader stated more bluntly, 'I see some problems for some of the older naturopaths that have not kept up and are reluctant to move towards an integrated model'.

Underlying this tension between older and more recent naturopaths are issues of education and medical science-based backgrounds. More recent naturopaths are all educated at the same school in Ontario with a curriculum that is increasingly emphasising medical science. Overall, it seems that the strategy of developing a more cohesive group is still required, especially in terms of disagreements between older and more recent naturopaths, even though the naturopaths have been successful in establishing a single organisational structure.

The big challenge for the TCM/acupuncture community is overcoming differences and increasing cohesion among the groups. Some of the leaders were aware of this imperative, but recognised that it would be difficult to pursue this strategy. As one leader explained:

> They have to get their act together. Historically, the regulated health professionals like doctors and chiropractors did not get along so well, but they have come to peace with each other and then get regulated. The Chinese organisations still have too much infighting.

This same leader believed it would be necessary for the government to step in and force the various factions to overcome their acrimony: 'I think that eventually some kind of mediator is going to have to come in and try to make some peace. We have to pull together and have a referee'. These are battles about knowledge claims and who are the 'true' acupuncturists:

> The acupuncturists and different associations share different views on how they should be regulated. That is an internal friction that causes a hurdle at the surface. Underneath the surface I cannot tell you the percentage, but some are not trained properly and they are afraid of getting regulated.

As mentioned earlier, there are significant divisions in the TCM/acupuncture community. There are two main splits in the community: the first is between TCM-based and Western-based acupuncture and the second is between various TCM associations and schools[3]. One TCM-based leader believes that the Western-based acupuncture organisations do not care what happens to the TCM-based practitioners, 'as long as [the Western-based organisations] are allowed to do what they want with acupuncture'.

By comparison, a Western-based leader said, in commenting on the divisions and the efforts to get TCM/acupuncture regulated '. . . we have tried darn hard to support this and it has gotten us nowhere because there are so many people who are being difficult'. In terms of the internal TCM divisions, one leader sums it up well:

> In the Chinese medicine population, we have true TCM doctors, Western-trained Chinese medical doctors who are trained in Western medicine

> doing acupuncture also. Westerners who studied acupuncture abroad or Westerners who have studied acupuncture locally. They are all calling themselves Chinese doctors or practitioners of TCM, but it is a very very different group.

The fights between these groups are about who will emerge at the top and whose standards will prevail. At the core of the disagreements are which TCM/acupuncture group has the most credible knowledge claim. One leader stated that while all the TCM-based groups wanted regulation, 'some disagree on certain details, *e.g.* different points of view about standards'. With so many different backgrounds and diverse approaches to healing, the contending interests among this group make it unlikely that the leaders will be able to increase the level of cohesion in the near future.

While most of the homeopathic leaders recognised the need to become more cohesive in order to advance their group interests, they had not been able to pursue this strategy and overcome their divisiveness. A leader put it this way:

> Once all of these associations and colleges come together and have a common platform, then the government will listen. Up till now we are working as splinter groups.

The various leaders are vying for control of homeopathy, and that competition is further dividing the group. One of the leaders explained it this way: 'It is just us three cowboys out here (the three principal leaders in Ontario) corralling off our own territory. We don't see eye to eye on a lot of things and it is very sad'. Since this interview took place, there has been another split in leadership and a fourth leader has emerged. Like the TCM/acupuncture group, reconciliation of the various members seems even more unlikely now.

As with TCM/acupuncture, the existing splits are about who has the most credible claim to homeopathic knowledge. As one leader put it, 'In homeopathy, there will always be other groups. They have lower standards. If the government decides to regulate according to our standards, they will be left behind'. Another leader, when talking about the advantages of regulation, also pointed to the boundaries between homeopaths, 'the practitioners would be better off [with regulation] because they would be recognised and would not have to compete with pseudo-homeopaths'. For the homeopaths, achieving cohesion seems a remote goal under these circumstances.

Discussion

The leaders of three CAM groups are engaged in strategies to position themselves to gain statutory self-regulation. Our analysis explores how internal

boundary work over knowledge claims is an underlying component of these strategies. At the core of this are battles over who is considered a competent practitioner. For naturopaths, the battle lines are between the older practitioners who received little medical science training and the recently trained practitioners whose education includes medical science. In the case of TCM/acupuncturists, the battle lines are between the Western and Chinese-educated practitioners; and for homeopaths, it is between practitioners with some medical science education and those who have less. Factions in all the groups rely on claims to medical science knowledge to identify 'legitimate' practitioners.

The infusion of medical science into the four specific strategies discussed in our analysis is part of the attempt of the CAM groups to gain professional dominance and some degree of social closure. Claims to medical science knowledge are used by some internal factions in an attempt to gain internal social closure over rival schools or groups. It is also important to note that developing a curriculum and standards that include knowledge of medical science is not merely about rhetoric. Although the infusion of medical science into their practices may align CAM groups with mainstream medicine and hence move their professional project forward, there is also the belief that medical knowledge is necessary in and of itself to allow practitioners to provide a safe and effective form of health care. Some of the leaders also make it clear that for protecting the public, medical science knowledge is necessary to improve the degree of care given to their clients. In addition, there is the need for CAM groups to manage their relationship with mainstream medicine – inclusion of medical science in the curriculum is a way to increase their legitimacy and move their professional project forward.

At the same time, however, recent trends in CAM highlight how the rhetoric of science is being co-opted by some CAM groups in order to gain legitimacy in the eyes of the medical establishment and the public. This rhetoric also serves to distinguish certain within-occupational factions from each other (*e.g.* Gieryn 1983). The CAM groups in our study are engaged in internal battles concerning boundary work around the rhetoric of science, including the inclusion of a medically-based curriculum, and the promotion of peer-reviewed research, is used to establish who are the legitimate claimants to the title of 'homeopath' or 'acupuncturist'. The construction of social boundaries between internal CAM groups on the basis of medical science has implications for which groups will gain professional dominance both within the CAM group and in the overall system of healthcare professions.

The TCM/acupuncture leaders also incorporate claims to TCM knowledge as part of what distinguishes the boundaries between various internal groups. Some TCM leaders believe they have superior knowledge because they combine both medical science with strong TCM education. Yet, even within this group, there are further boundaries drawn that distinguish who possesses the true TCM knowledge. Those educated in China, for example,

believe their knowledge claims are strongest. Norris' (2001) study of the strategies used by New Zealand musculo-skeletal practitioners shows that practioners do not rely on science alone to distinguish their knowledge base from that of another group. Practitioners use concepts such as holism and prevention to illustrate the advantages of their approach and to demarcate their practice from others. Because of the large amount of treatment overlap and the use of similar treatments by both conventional and alternative practitioners, Norris concludes that appealing to science as the boundary between different forms of treatment is difficult to do. For the TCM/acupuncture leaders in our study, their claim that one is more medically science based than the other have to compete with claims around who is the truest proponent of TCM.

The leaders of the TCM/acupuncture group, however much they might wish to present a united front to the public or government, or to decide on uniform standards of education and practice, have not been able to do so because of their internal differences. The divisions caused by language, culture, different traditions of training and variance in the importance of medical science versus traditional Chinese philosophy in the healing process make it difficult for TCM/acupuncture groups to pursue the strategies discussed in the way the more cohesive naturopaths can. In terms of the infusion of medical science knowledge, Saks (1994) finds similar processes at work in Britain as non-medical acupuncturists are attacked for their lack of biomedical training. The homeopathic leaders are also at a disadvantage when they contemplate putting many of these strategies into place. Their discipline is characterised by dissension about the most appropriate standards of education and practice for homeopaths as well as by personal competition among a number of charismatic leaders, each with their own following.

Our findings make it clear that while a cohesive organisational structure may not be sufficient to ensure that a group attains state-sanctioned self-regulation, it is nevertheless an essential condition for activating the strategies that can achieve this goal. It is interesting to note that a recent British report on the current and future position of CAM groups in that country also mentioned the problems posed by fragmentation and diversity within the field (The Prince of Wales' Initiative on Integrated Medicine, 1997). The discussion document revealed a clear pattern; where professional organisations within a CAM group had joined forces or worked closely together, there were 'impressive developments in terms of self-regulatory structures, improved standards of training and greater public recognition' (1997: 29). In groups, like the ones analysed here, lack of cohesion can seriously hamper the professionalization process.

A second challenge for CAM groups wishing to move toward regulation and professional acceptance is the external demand, posed mainly by medicine and the state, for peer-reviewed research on the efficacy, safety and cost-effectiveness of their practices. The leaders of the naturopathic group

realised that such research was necessary if they were ever going to be regarded as legitimate by other healthcare professions and government. While they all acknowledged that this kind of scientific research must be done, there was not a great deal of enthusiasm to undertake it. The leaders of the other two CAM groups were divided on the necessity for research. In both, the majority believed that there was already ample proof that their therapies work. Hence, they perceived little incentive to pursue this particular strategy.

In a society that is increasingly concerned with 'evidence-based health care' (Best and Glik 2000), this lack of interest in further research is likely to be a serious obstacle for groups that wish to become self-regulating. As demands for evidence-based health care increase both in mainstream medicine and in the field of CAM, the generation of peer-reviewed research assumes critical importance for the distribution of power in healthcare. Yet, there is ambivalence about this voiced by the CAM leaders in our study. Part of the ambivalence points to the tension between their claims to scientific knowledge and their 'alternative' medical focus. Many of the leaders, with the exception of the medically-based acupuncturists, believe that RCT methods of study are incompatible with CAM. Using the strategy of promoting peer-reviewed research is fraught with problems for it is not clear what this research should look like. While more RCT studies may bring CAM research into alignment with the methods of mainstream medicine, these types of studies do not provide the kind of proof many CAM leaders feel is most appropriate for demonstrating the effectiveness of their treatments.

Conclusion

The strategies outlined here all influence one another and cannot be viewed in isolation. There is no single linear path to state-sanctioned self-regulation. Some strategies work better for certain groups than they do for others. The distinctive history, philosophy and characteristics of a group shape the ways in which they adopt one strategy more energetically than another. In the case of TCM/acupuncture, for example, the split between the medically-educated practitioners and those who were trained in less formal ways means that today they cannot reach a consensus on standards of education or practice.

It is worthwhile considering what these groups may be giving up to become self-regulated. In order to meet the necessary criteria, complementary and alternative practitioners must adapt to a more medical model of healthcare than the one to which they have been accustomed. For example, the chiropractors in Canada had to agree to narrow their scope of practice in order to achieve a cohesive national organisation and a unified voice (Coburn and Biggs 1986). The midwives in the province of Ontario changed their educational model from an eclectic apprenticeship to a more standardised

baccalaureate degree programme to fit into the existing health-care system (Bourgeault 2000). In both cases, the external socio-political pressures influenced them to make internal changes that were more in alignment with conventional medical practice. In the future, CAM groups seeking self-regulation may be forced to construct a professional identity that departs from their founding identity and incorporates elements of the medical model. They run the risk of mistaking the allopathic medical model for the paradigm of professionalization. This does not have to be the only road taken though. Frank (2002) finds some evidence that German homeopaths are not sacrificing central homeopathic tenets in order to gain legitimacy in the German healthcare system.

The leaders of the three groups in our study are committed to moving their disciplines forwards and achieving some degree of professional dominance. The form in which they proceed depends not only on internal factors such as cohesiveness of membership and uniformity of vision, but also on external factors such as barriers erected by other healthcare groups, and the readiness of government to respond to requests for self-regulation. Whether or not a specific group employs every strategy delineated here, there are no guarantees of success. Forces such as resistance from the more established health professions and other competing would-be professions as well as government concerns about efficacy, safety and cost effectiveness have to be balanced against the growing public demand for CAM services. Ultimately, when a group becomes self-regulated it is at the end of a long political process.

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Notes

1 In Canada, which has a publicly-funded health care system (covering medical doctors and hospitals), regulation of health practitioners is a provincial responsibility (Casey 1999, Boon and Verhoef 2001). While a few CAM practitioner groups are currently regulated in certain provinces, most are not regulated at all. Indeed, some groups are not even interested. The only CAM group that is regulated in every province is chiropractic.

2 CAM leaders often spoke of 'double-blind scientific studies' when referring to RCT studies. They also used the term 'clinical evidence' to refer to observational studies of their clients or others. The use and misuse of terminology for studies, although beyond the scope of our current analysis, also supports our notion that science is at the centre of the demarcation of boundaries for CAM groups.
3 The leaders can be categorised into two groups according to their view of how acupuncture should be practised. One group sees the practice of acupuncture as an inherent part of TCM and its theoretical underpinnings. The other group regards acupuncture as a treatment modality in its own right that is useful to a range of healthcare providers, including Western medical doctors, dentists and nurses. Complicating this fundamental division are language barriers and cultural differences. Practitioners in the first group tend to have been trained in China and speak Chinese as their first language. Most of the practitioners in the second group were born in Canada and educated at Canadian acupuncture schools.

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