

# No alternative? The regulation and professionalization of complementary and alternative medicine in the United Kingdom

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## Abstract

In conjunction with its growing popularity, complementary and alternative medicine (CAM) in the United Kingdom has witnessed increasing professionalization, partly prompted by the landmark Parliamentary Inquiry that reported in November 2000. Professionalization has become a significant strategy for practitioner associations and a key focus for the government, media, and patient groups. It is being driven by concern over the interests of patients and consumers, and in relation to the possible integration of certain forms of CAM into publicly funded healthcare. It is, moreover, being reconfigured in explicitly national terms. This paper draws on research into practitioner associations representing nine CAM modalities in the UK—aromatherapy, Chinese herbal medicine, chiropractic, crystal healing, feng shui, ‘lay’ homeopathy, medical homeopathy, osteopathy, and Radionics—, examining the recent wave of professionalization in relation to Foucault’s concern with ‘techniques of the self.’ It highlights the contrasting experience of an association of Chinese herbalists seeking statutory self-regulation (SSR) and an association of chiropractors that was instrumental in securing SSR for chiropractic.

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## Introduction

In the wake of its recent upsurge in popularity in the West, complementary and alternative medicine (CAM)<sup>1</sup>

looks set to become “a permanent feature of our cultural landscape” (Douglas, 1996, p. 49). Much social science research has focused on the burgeoning demand for CAM, variously attributed to dissatisfaction with orthodox medicine (Sharma, 1992), a desire for holistic treatments that value patient experience (Bakx, 1991; Douglas, 1996; Scott, 1998), the emergence of ‘smart consumers’ seeking self-empowerment through active healthcare decision-making (Doel and Segrott, 2003a; Kearns, 1997; Wiles and Rosenberg, 2001), or seen as symptomatic of an age of cultivated anxiety (Doel and Segrott, 2003b; Furedi, 2003). The provision of CAM has received comparatively less attention (though see

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<sup>1</sup>Whilst the catch-all phrase ‘complementary and alternative medicine’ has become commonplace, it remains an unfortunate designation in that it implies subservience to an unacknowledged and hegemonic orthodoxy, connotes a false sense of unity, and fails to acknowledge that the purview of its referents extend beyond the narrow confines of medicine.

Cant and Calnan, 1991; Cant and Sharma, 1998; Dew, 2000; Tovey, 1997a, b), despite rapidly rising numbers of practitioners, practitioner associations, and regulatory bodies (Mills and Budd, 2000; Saks, 2000). This aspect is significant because expanded provision often leads to changes in practice, which in the UK has crystallized around a multifaceted process of self-conscious ‘professionalization.’ As Cant and Sharma (1996b) demonstrate, professionalization has the potential to alter radically the work of practitioners, their interactions with patients, and public perceptions.

Whilst work on professionalization has increased across the social sciences, it is particularly instructive in relation to CAM, which represents an incredibly complex, fractured, and uneven field of practice that is bordered by the tightly regulated, highly professionalized, and well-integrated field of orthodox medicine (Larkin, 1983): although the latter is no less intrinsically heterogeneous and ambivalent than CAM. What has not been appreciated, however, is the explicitly *spatial* nature of professionalization. CAM practitioners do not simply happen to perform CAM in the UK or elsewhere, localizing a repertoire of therapeutic practices in situated encounters with patients and clients. Professionalization is not merely concerned with inculcating a ‘professional’ form of conduct. Crucially, through the process of professionalization, CAM practitioners are being reconstituted as *national* subjects—subject first and foremost to regulatory authorities with an explicitly national jurisdiction (the UK legal system, Department of Health, Medicines and Healthcare Products Regulatory Agency, General Chiropractic Council, etc.).

In focusing on the spatiality of the professionalization of CAM, this paper is concerned with the overdetermination of the local by the national. This is most keenly felt at the level of practitioner associations, which have become the principal means through which the nationalization of CAM is accomplished. Accordingly, we have chosen to concentrate on the way in which practitioner associations have mediated the professionalization of CAM. This is exemplified by the incorporation of explicitly national (principally governmental) concerns into membership requirements, rules and regulations, codes of ethics and conduct, disciplinary procedures, agenda items, journal articles, editorial statements, etc. However, this overdetermination and nationalization of CAM by the discourses and practices of ‘professionalism’ has not gone unchallenged. Since professionalization must pass through a host of spaces (local, regional, and national networks and associations of practitioners; training courses and conferences; clinics and hospitals; and a plethora of media: journals, newsletters, etc.), there are numerous opportunities for practitioners to renegotiate, transform, resist, and elude this process (Doel and Segrott, 2004; Fitzgerald and Hawkins, 2003). Indeed, although most

practitioners are affiliated to national practitioner associations (Fulder and Munro, 1985; Mills and Budd, 2000), relatively few become actively involved, tending to develop local interpersonal networks instead (Sharma, 1992). The growing need for collective representation in the wake of rising regulatory pressure consequently has the potential to amplify tensions between individual practitioners and their respective associations. Accordingly, this paper explores the way in which ‘professionalization’ is actively engendered through the networks of information linking individual practitioners to their national associations, drawing primarily on an analysis of documentary material that circulates amongst them.

Our initial focus is on the way in which the benefits and costs of professionalization are presented by practitioner associations to engender the support of their membership, with particular reference to an association of Chinese herbalists, which actively lobbied for statutory self-regulation (SSR). Here, the question of reduced autonomy for individual practitioners reveals itself as a source of disquiet. What such reduced autonomy might amount to is considered in the latter part of the paper, in relation to an association of chiropractors that has been instrumental in securing SSR for its membership. Whilst SSR is seen to centre primarily on standardization, CAM seems intrinsically inimical to this process. The highly personalized nature of many practices, which depend upon situated encounters and practice-based experience, resist codification and assessment against universal criteria (Cant and Sharma, 1996b; Fulder, 1992). Accordingly, regulation often proceeds by acknowledging the performative autonomy of individual practitioners and the indeterminate nature of many CAM practices, avoiding rigid definitions and eschewing direct control. Instead, clinical practice is governed indirectly, through the construction of forms of conduct and competence that practitioners are expected to embody (Fournier, 1999; Miller and Rose, 1990). Governmentality increasingly focuses on the *subject*, rather than the practice, of CAM; and as Guattari (2000, p. 62) reminds us, “new modalities of subjectification are continually emerging.” Having problematized the practitioner, both regulators and associations are seeking to construct a new kind of subject who can be entrusted with the practice of CAM.

### CAM, knowledge, and space: the UK context

Despite a longstanding trend toward professionalization across all manner of occupations (Perkin, 1989), CAM in the UK has only relatively recently become self-consciously caught up in this process, as orthodox medicine has moved from a position of outright rejection towards selective incorporation. This arguably

marks one of the most significant changes in healthcare since the original marginalization of certain practices into a residual, 'alternative' category with the creation of the medical professions in the mid-19th century: at which time a variety of exclusionary strategies were employed to delegitimize such 'heretical' practices as homeopathy, though not without considerable resistance (Barrow, 1991). Whilst representing a belated reaction to this original marginalization, the current wave of professionalization within CAM adopts similar strategies to those once deployed against it: particularly regarding claims to specialist (albeit heterodox) knowledge (Sharma, 1992). Most work on professionalization highlights the use of expert knowledge as a source of authority, legitimacy, and status; particularly by means of its demarcation from other areas of professional expertise, as well as from lay knowledge. Claims to expert knowledge are typically protected by extensive formalization and time-consuming socialization. Education and training (enshrined in accreditation schemes), and rigorously defined standards of practice (set out in codes of conduct and ethics, disciplinary procedures, and continuing professional development (CPD) programmes), are established as means of 'policing' professions (Cant and Sharma, 1996b; Fournier, 1999; Nettleton, 1995). The question of who polices such 'policing' activity, however, has been raised in a way that has profound spatial implications.

Although the Parliamentary Inquiry conducted by the House of Lords Science and Technology Select Committee during 1999 and 2000 rejected wholesale SSR for CAM, it emphasized the incompatibility of effective regulation and fragmented organization. The Committee consequently recommended the formation of a single, national regulatory body for each CAM modality (House of Lords, 2000, Section 5.5). In the fullness of time, every UK-based CAM practitioner should ideally become subject to a unitary regulatory authority with a national purview. This has already been accomplished for chiropractic and osteopathy, each of which has several practitioner associations but only one statutory regulator charged with enforcing the legal protection of title, maintaining a register of practitioners, and defining and defending nationally defined standards.

For many practitioners and their associations, the bitter pill of increased regulation and national unification is considerably sweetened by the prospect of greater status and recognition. As Foucault (1997, p. 95) reminds us, since Antiquity "Attending to oneself is a privilege; it is the mark of social superiority, as against those who must attend to others." Consequently, the Committee's recommendations were favourably received by many practitioner associations, eager to secure their social standing. Noting that SSR had been recommended only for "two [CAM] professions, herbal medicine and acupuncture, plus possibly homeopathy

in the future," an association of aromatherapists reported in its Journal (March 2001) that "Letters have been sent out to the Minister of Health and the Chairman of the Select Committee pointing out that the aromatherapy profession is ahead of the game in seeking statutory regulation." Numerous other associations mounted similar campaigns. The way in which this apparent clamour for SSR has worked itself out within different practitioner associations is, however, contingent and contested.

## Methodology

It has been estimated that in the UK *c.* 70,000 CAM practitioners (including *c.* 10,000 orthodox healthcare professionals under statutory regulation) are represented by *c.* 170 practitioner associations (Mills and Budd, 2000). Our research focused on nine UK-based associations, representing practitioners of aromatherapy, Chinese herbal medicine, chiropractic, crystal healing, feng shui, 'lay' homeopathy, medical homeopathy, osteopathy, and Radionics. This reflects the diversity of the field in terms of organizational size, structure, CAM modality, philosophical basis, relationship with orthodox medicine, and assessment by government. Importantly, it includes associations representing practitioners in each stratum of the threefold typology advanced by the House of Lords (2000, Box 20): the '*principal disciplines*' of acupuncture, chiropractic, herbal medicine, homeopathy, and osteopathy; therapies *complementing* orthodox medicine, such as the Alexander Technique, aromatherapy, reflexology, shiatsu, and meditation; and *alternative disciplines*, largely indifferent to orthodox medicine and its scientific foundations, such as Ayurvedic medicine, Chinese herbal medicine, crystal therapy, dowsing, and Radionics.

In order to investigate the ways in which knowledge circulates through a variety of practitioner networks, we asked each association to supply us with all the documentation they produce for their membership: newsletters and journals; information about training opportunities, accreditation, and career development; codes of conduct and disciplinary procedures; advertising and promotional literature; etc. Such materials were provided from June 2001 to May 2003. Unlike Cant and Sharma (1998, p. 262), who were struck by the failure of CAM-based associations "to enforce rigid boundaries between internal (private) and external (public) knowledge," we had to engage in protracted negotiations with many of the associations (e.g. aromatherapy, Chinese herbal medicine, chiropractic, and homeopathy associations), and most of the associations requested anonymity. Far from lacking an appreciation of the need for a public façade, these associations were acutely aware of the risks of adverse publicity. Heightened is one of the

most important transformations in the spatiality of CAM knowledge. Professionalization is first and foremost an attempt to (re)gain control of CAM in public space.

Once collected and collated, the documents were subject to a content analysis that focused on how each association reflexively presented the modality in question to its membership (in order for practitioners to have a critical awareness of themselves), and how it situated the embodied practice of therapists in relation to regulation and professionalization (in order for practitioners to have a regard for how they conduct themselves). This accords with Foucault's (1997) genealogical investigation of the 'techniques of the self,' expressed in the twofold obligation to 'know' and 'care for' oneself. As we demonstrate, the professionalization of CAM is an attempt to honour this obligation in an era of increasing regulatory concern. Becoming professional is not an adjunct to knowledge and practice that leaves them intact. It necessarily recasts them. This is evident in the documentary evidence for all nine associations. Consequently, professional practice is not simply opposed to unprofessional practice. It is also opposed to practice qua practice. Only *professional* practice will henceforth suffice. This exclusivity is non-negotiable, as the 'closure' of registers and the 'protection' of title for healthcare professionals under SSR demonstrates. In other words, 'professionalism' makes a practice—and a virtue—out of itself. As ever, form overdetermines content—and yet the experience of different practitioner associations is not necessarily homogeneous. Of the nine associations studied, the association of chiropractors and the association of Chinese herbalists were most explicitly concerned with putting 'professionalism' into practice. Their contrasting experiences to help elucidate the complexity of this process.

### Regulation and professionalization

Self-regulation is something of a misnomer. Far from enabling each individual to regulate him or herself, self-regulation within CAM is forged at a (nationally conceived) *collective* level (e.g. chiropractic), rather than at the level of the individual *practitioner* (e.g. chiropractors). For while self-regulation is concerned with practitioners, it is only concerned with them to the extent that they express—or fail to express—what is essentially impersonal. As Genosko (2000, p. 114) puts it, "Subjectivity is a group phenomenon. It is completely deindividuated and depersonalized and ecologized, a consequence of foregrounding the social environment of the institution." Furthermore, insofar as the *collective* becomes both the subject and object of self-regulation,

one can appreciate why the Select Committee insisted upon the necessity of a *unified* profession.

Self-regulation is intimately related to 'techniques of the self' (Foucault, 1997), since individual practitioners are expected to integrate the precepts of self-regulation within their own situated practices. Self-regulation therefore presupposes a unity of practice that is invariably forged around an explicitly national frame of reference. Yet in becoming subject to—and the subject of—an idealized and impersonal repertoire of 'professional' practices, the practice qua practice of practitioners risks becoming estranged from itself. As Foucault (1990, p. 48) argues in a rather different context, such an estrangement is much more than alienation: "[I]t is suddenly to feel grow within oneself a desert at the other end of which (but this immeasurable distance is also as thin as a line) gleams a language without an assignable subject, a godless law, a personal pronoun without a person, an eyeless and expressionless face, an other that is the same." For example, the Rules of Conduct of an association of Radionic practitioners state that "No member shall conduct himself in a manner as to prejudice the profession of Radionics ... or his own professional status as a Radionic Practitioner." The emphasis placed on the need for all CAM practitioners to secure informed consent from their clients, appreciate their own limits, know the scope of their discipline, and employ effective referral procedures to other healthcare professionals when clinical circumstances dictate are hallmarks of the professionalization discourse.

Professionalization accords precisely with the "obligation to know oneself" for the "training of the self by oneself" discussed by Foucault (1997, pp. 227 and 208, respectively). Indeed, the "art of self-government" (Foucault, 1997, p. 90) ushered in by SSR differs markedly from the climate of "charismatic therapists, who learnt their 'art' through apprenticeship... and practiced independently and energetically," that characterized the original 'renaissance' of CAM in the 1970s (Cant and Sharma, 1996c, p. 157). The current emphasis on consent, limits, scope, and referral often channels professionalization towards the margins of therapeutic practice: to what is shared amongst professions, such as clinical notes; codes of conduct and ethics; and CPD. Such measures are often seen as expedients on the road to SSR, being introduced alongside significant organizational restructuring (the unification of disparate associations, creation of a central register of practitioners, establishment of reporting mechanisms for adverse reactions to treatment, etc.). They are, however, a form of estrangement.

Saks (2000, p. 230) notes that professionalization typically provides "positive benefits to those involved in terms of enhanced income, status and power, as well as the satisfaction of working in a well-regulated

profession.” Whatever the benefits in terms of legitimacy and status, however, professionalization inevitably imposes additional costs, not only in terms of financing new regulatory bodies, but in potentially imposing greater heteronomy with respect to individual practice. In actively promulgating the need for tighter regulation, therefore, most practitioner associations have sought to vindicate their stance by referring to the increased visibility and public scrutiny of the safety and effectiveness of CAM. Indeed, many associations are actively encouraging evidence-based research amongst their membership. However, given the apparently high levels of patient satisfaction responsible for fuelling the growth of CAM in the first place, placating consumer anxiety should probably be seen as secondary to a (self-propelling) conviction regarding the necessity of preemptive action to fend off the imposition of stricter regulation by government agencies. A forthright statement to this effect appeared in the Newsletter of an association of homeopaths (Autumn 2002): “[I]t has been made very clear ... that we are expected to become a more responsible profession and regulate ourselves in an acceptable way. The unspoken bit is of course that if we do not do it for ourselves, it will be done for us!”

Associations typically present professionalization to their members as both a pragmatic necessity—since unprofessional conduct is self-evidently culpable—and a positive strategy, designed to ensure the continued relative autonomy of the modality as well as increased legitimacy for its practitioners. Yet given that truly autonomous professions are increasingly viewed with suspicion, professionalization may deliver patient protection, legal security, increased status, and heightened legitimacy only at the cost of reduced autonomy for individual practitioners. In an era of diminishing trust, professional practice has become inextricably linked to discourses of transparency and accountability that make ostensibly unorthodox practices commensurate with more orthodox forms of governmentality (Greenwood and Lachman, 1996; Power, 1997). It is, therefore, unsurprising that the association of Chinese herbalists, like most other practitioner associations, should have actively lobbied for SSR. Far from favouring Chinese herbal medicine for SSR, however, the Select Committee relegated it to the third tier of its typology; judging it ‘potentially dangerous.’<sup>2</sup>

This notwithstanding, the association of Chinese herbalists remained committed to attempting to secure SSR for its membership, arguing that “moving towards

Statutory Self Regulation of herbalists ... will provide us with professional recognition, protection of the title ‘herbalist’ and the authority to use scheduled herbs that are not available as over the counter remedies” (Newsletter, Summer 2001). Whilst admitting that SSR is “not without costs,” the association depicted it as “the best option we have. It will afford greater protection to patients, give greater credibility to registered practitioners, and allow herbal medicine to become more visible while preserving to a high degree the autonomy it currently enjoys” (Newsletter, Autumn 2001). SSR dominated the association’s agenda at least in part because of a number of high-profile safety scares. One Newsletter (Autumn 2001) singled out “the unregulated nature” of the recent upsurge of growth in Chinese herbal medicine as having “brought safety issues to the fore.” Accordingly, “One way of protecting the pharmacopoeia while addressing safety concerns is by developing a ‘practitioner-only’ list of herbs which would limit the more potent herbs to registered practitioners” (Newsletter, Summer 2001).

Much of the association’s argument hinged on the specialist knowledge required in determining the quality and correct usage of herbal remedies. By their nature, herbal products are not standardized, varying according to cultivation conditions, the part of the plant used, preparation methods, etc. Levels of quality assurance also vary between suppliers, generating concerns over authenticity, adulteration, and toxicity. Special care and expertise is needed to ascertain the authenticity, strength, and age of herbs, along with an understanding of how to prepare them. The association of Chinese herbalists sought to raise the quality-assurance mechanisms of herbal suppliers, challenge what it saw as unnecessary restrictions on particular herbs, and present SSR as the logical solution to the problems raised by the complexity of herbal medicine. The Department of Health (2004) has since put forward proposals for the SSR of herbal medicine, including its Chinese and Western traditions.

The pragmatic nature of the herbalists’ argument bore all the hallmarks of the claims to specialist knowledge that underpin professionalization. In a candid statement, a Newsletter of one herbalists’ association contended that “a rejection of the privileged status of statutory self-regulation would be seen by government, other healthcare professionals and the public as a sign that delivering high quality patient care was not our first priority.” This should perhaps also be read in the light of the more prosaic consequences of SSR, which include the possibility of access to paid work in the public-sector National Health Service (NHS).

Given that SSR formalizes the legal rights of practitioners, safeguards against incompetent and unethical practice, and protects the pharmacopoeia, it has been portrayed as helping to preserve the identity of

<sup>2</sup>The differential evaluation of Chinese herbalism and acupuncture confounded practitioners of Traditional Chinese Medicine, which employs *both* in an integral fashion on the basis of an understanding that is fundamentally incompatible with their separate assessment as undertaken by the House of Lords Select Committee.

Chinese herbalism, which is currently being eroded with each decision to proscribe individual herbs. Despite the association of Chinese herbalists subscribing to this position, some practitioners fear its consequences in terms of external interference, the bureaucratic need for transparency and accountability, the circumscription of individual practice, and the potential for individual practitioners to be excluded—either financially (since the trappings of professionalism invariably come at a cost) or legally (they may be removed from the register). SSR can also be viewed as undermining the autonomy of Chinese herbal medicine through the dilution of its philosophical base. Numerous studies suggest that professionalization involves “accommodation to the bio-medical model” (Baer et al., 1998, p. 533). Thus, homeopathy has reportedly amended its knowledge base—dispensing with certain philosophical claims and increasing tuition in biomedical theory—in the hope of enhancing legitimacy (Cant and Sharma, 1996a); and chiropractic has debated the intelligibility of ‘subluxation,’ both within chiropractic and to other healthcare professionals.

Sharma (1992) suggests that whilst CAM practitioners enjoy lesser status than professionals working within the NHS, their freedom from bureaucratic control partly compensates for this (cf. White et al., 1997). Certain dissenting practitioners featuring in the letters pages of association publications articulate such an understanding. Debating the contention that by gaining respectability Chinese herbal medicine risks losing its unique tradition, one contributor claimed: “[P]ractitioners in the Alternative field, while disliking the SSR scheme as I know many do, seem unable to think through the logical conclusion, which is that they will end up being led by the nose into Government control without any autonomy or self-determination” (Chinese herbalists’ Newsletter, May 2002). Similar concerns were expressed by other associations. For example: “If regulation is synonymous with professionalism, then many CAM disciplines are well on the way to achieving this. Those who do not regulate, or at least have unified registration, will find themselves marginalized yet again” (Radionic practitioners Journal, Spring 2003).

Rather than safeguarding autonomy, professionalization increasingly involves forming contacts with a range of other professionals; especially orthodox healthcare professionals. Although a key attraction of SSR propounded by many practitioner associations is that recognition by the orthodox medical profession establishes the possibility of working within the NHS, some fear that this would amount to co-optation. For example, rather than representing an autonomous, holistic form of healthcare, Chinese herbalists may be restricted to treating only those patients deemed suitable by the healthcare orthodoxy. Saks (2000, p. 122) notes that when nurses and physiotherapists gained profes-

sional recognition this was subject to “subordination to the medical profession or at least limitation to a specific area of work.” Likewise, acupuncture has largely been treated reductively by orthodox medicine as a form of analgesia. The prospect of widespread access to NHS patients is, moreover, only a possible outcome of SSR. To date, such access has been based on highly localized agreements, typically involving individual practitioners. Although chiropractors and osteopaths have attained SSR, they have made few inroads into the NHS, continuing to work almost exclusively on a self-employed basis in the private healthcare sector.

### Professionalization as regulation

Many CAM practitioners are not fully embedded within organizational structures. They work as self-employed businesspeople, enjoying a significant degree of freedom over their work practices (Andrews et al., 2003; Sharma, 1992). The new-found government concern with the safety of healthcare consumers has ensured a drive for standardization led by those concerned to protect the public interest, as well as by practitioner associations concerned to preserve the integrity of their disciplines. Yet standardization is not unproblematic, either in the specific case of CAM or more generally. In fact, professionalization has *itself* become an important regulatory mechanism in those areas of economic life requiring a degree of autonomy on the part of individuals but where control cannot be relinquished entirely (Fournier, 1999; Miller and Rose, 1990). The ‘discretionary gap’ opened up by such relative autonomy has come to be managed by the construction of forms of conduct and competence that workers are encouraged to embody, master, and habituate into their repertoires of practice. Foucault’s (1973) discussion of the emerging regulation of the medical profession in France towards the end of the eighteenth century provides the classic example. The need to control medical practice in the face of a growing body of unqualified, incompetent, and unethical practitioners, combined with a desire to avoid returning to corporate restrictions on who might enter medicine, resulted in a governmental form that controlled the medical act “at a distance ... by regulating the ‘competence’ of the subject of medical truth. Hence, the task of the profession [came] to centre upon the establishment of conditions for assessing the competence of practitioners” (Osborne, 1993, p. 348).

There is, however, both a definite tension and a complex interplay within CAM between standardization, which seemingly implies practitioner heteronomy, and professionalization, which apparently implies autonomy. Standardization typically aims to reinforce and regulate the distinct knowledge and skills base

defining any given practice. A standardized training curriculum and the codification of common criteria against which individual practitioners' competency and safety may be judged are amongst the key factors necessary for distinguishing qualified practitioners from inadequate, incompetent, and potentially unscrupulous, untrained individuals. Whilst standards as such are hardly new, existing procedures are increasingly being formalized, with extensive documentation, accreditation, and disciplinary mechanisms becoming progressively strengthened. Nonetheless, standardization poses particular difficulties within CAM. Any given practice typically consists of diverse, often contested, principles and techniques, frequently deriving from a variable institutional basis. For instance, different training schools have typically evolved their own traditions and interpretations: where some have seen themselves as innovators, others have sought to return to foundational principles, often in response to their perceived diminution within major training establishments. This underlying plurality is well illustrated by the chiropractic association's rejection of the 'international' paradigm developed by colleges in the United States, since "it is not exactly in tune with the definition of chiropractic as given by the General Chiropractic Council" (Journal, September 2001). Moreover, where a range of practitioner associations exists (typical of most CAM modalities), there is often considerable divergence with respect to the initial and continuing education and training requirements, and the codes of ethics and conduct to which members must adhere. Thus, the task of forging consensus presents a considerable challenge.

The difficulties stemming from different institutional traditions are ramified by the personalized nature of most CAM practices. Homeopathy, for instance, claims to treat unique individuals holistically, rather than isolating and targeting specific illnesses; and many CAM therapists argue that their practices draw upon a kind of indeterminate, situated knowledge gained through experience: a form of craft knowledge inherently resistant to codification. This notwithstanding, regulatory bodies increasingly view practitioners merely as conduits for the effective delivery of recognized forms of treatment, with little room for idiosyncratic variation. Many practitioner associations subscribe to this logic. The chiropractic association, for example, has attempted to determine the definitive qualities of the chiropractor. A working group, charged with devising an initial list of qualities for subsequent consultation with members, proposed such statements as "chiropractic is gentle" and "chiropractors treat the whole body, not just backs and are able to treat problems of the joints and muscles and their effect on the nervous system" (Journal, January 2001) as unobjectionable 'markers.' The aim of the exercise was to create an identifiable brand that, ideally, individual practitioners ought to personify: "The object

... is to arm the subject with a truth it did not know, one that did not reside in it; what is wanted is to make this learned, memorized truth, progressively put into practice, a quasi-subject that reigns supreme in us" (Foucault, 1997, p. 102). Moreover, "The reason the [chiropractic association] has a logo and a corporate image, and sticks to a rigid set of rules about how it must appear, is because people learn to recognize a logo, and associate it with certain qualities. ... [T]he logo represents quality care—the gold standard for the chiropractic profession" (Promotion Pack). If the necessity of such an exercise suggests a sense of uncertainty about the practising subject of chiropractic, it also represents a pragmatic form of product differentiation, in view of the fact that chiropractors are not permitted to differentiate themselves on the grounds of ability and efficacy or even specialism and expertise.<sup>3</sup>

Despite such rationalizations, moves towards standardization have not gone unchallenged by practitioners. The letters pages of association publications provide space for dissent. Thus, a correspondent to the Chinese herbalists' Newsletter (Autumn 2001) asks:

Who is an effective practitioner, the person who can recite Bensky [a key textbook] or the person who can manage patients in a clinical situation with a good grounding in herbs and the perseverance to research their herbs[?] ... No training is ever going to be able to standardize 'bedside manner'—perhaps the most important reason that many patients come to complementary medicine in the first place.

There are also concerns that standardization may lower standards; typically where the compulsory registration entailed by SSR has led to the reduction of the differing standards of a number of pre-existing practitioner associations to a 'lowest common denominator.' One chiropractic association has found itself in the paradoxical position of attempting to maintain higher standards than those required by the regulatory authority. Furthermore, European-wide standards for chiropractic education and practice are viewed in some quarters as having been set too low. European legislation governing the freedom of movement of healthcare professionals (which permits chiropractors from other EU countries to practise in the UK for up to four

<sup>3</sup>For example: "No claim shall be made by chiropractors that the services which they are able to offer, or their personal qualities or skills, are in any way superior to that of any other chiropractor" (Code of Practice, General Chiropractic Council). Or again: "No Qualified member shall be permitted to use any general description signifying his function as a practitioner of Radionics other than the description 'Radionic Practitioner'" (Rules of Conduct, an association of Radionic practitioners).

months per year without registration) has raised similar concerns.

The difficulties posed by standardization have granted a significant regulatory role to professionalization itself. In the case of chiropractic, the new statutory body has not sought to impose unified, rigid definitions. The General Chiropractic Council's Standard of Proficiency guidelines state: "Chiropractic is an independent primary health care profession. In common with other such professions, the law does not attempt to define precisely ... the scope of chiropractic." Yet the degree of autonomy and discretion on the part of the practitioner this permits is immediately cast as a responsibility as much as a freedom:

Chiropractors must know their own limitations to the same extent as other regulated health professionals. It is not appropriate to restrict the clinical freedom of chiropractors to select the procedures that in their judgement are the best for the patient and most suited to their skills and experience. Nevertheless there must be boundaries and these will be set by what is the current sound practice of a reasonable chiropractor. (Standard of Proficiency guidelines)

This accords with Fournier's (1990, p. 287) account of the way in which the "inscription of competence in personal conduct, in the person of the practitioner, allows for the government of professional practice 'at a distance'"—which Brown and Duncan (2002, p. 364) aptly summarise as not "repressive but as positive and productive," locating it at the forefront of the new discourse of public health. In Fournier's (1990, p. 287) words:

Through the notion of competence, truth and knowledge are translated into a code of proper appropriate conduct which serves to construct the subjectivity of the professional practitioner. Truth governs not by controlling directly the acts (or even the knowledge) of the professional practitioner but by making sure that the practitioner is the sort of person who can be trusted with the truth. Thus an important characteristic of professional competence is its reliance on technologies of self (e.g. through careful selection and strong doses of socialization) rather than merely on technologies of domination.

For example, most General Chiropractic Council documentation avoids a prescriptive stance with respect to treatment. And whilst training courses deal with when and how to perform a spinal manipulation, medical procedures themselves are rarely subject to direct regulation, which is deflected onto the ideal of the competent professional.

Nowhere is this more evident than in the case of CPD, which is now mandatory for practices regulated by statute. The very idea of *continuing* professional development accords with Foucault's (1997, p. 96) insistence that "Attending to oneself is ... not just a momentary preparation for living; it is a form of living." Thus, registered chiropractors must follow an annual cycle of CPD—yet whilst the Council reserves the right to specify training elements, "[I]ndividual practitioners will be responsible for reflecting on and assessing their own learning needs and interests, planning their own CPD in their own Personal Development Plan, undertaking formal and informal learning, and detailing how this has affected their practice each year" (CPD Proposals and Implementation Plans, July 2001). This exemplifies perfectly the 'care of the self' through 'knowing oneself.' "What should one do with oneself? What work should be carried out on the self? How should one 'govern oneself' by performing actions in which one is oneself the objective of those actions, the domain in which they are brought to bear, the instrument they employ, and the subject that acts?" (Foucault, 1997, p. 87).

The competence and probity of practitioners' communication skills (issues of informed consent, explaining risks and procedures, etc.) are, however, more amenable to direct forms of regulation, and activities such as advertising and note-taking are dealt with in detail in the guidelines of professional associations and regulatory authorities alike. Significantly, many of the disciplinary cases brought before the Council have related to issues of communication with patients, conduct, note taking, and advertising, rather than clinical negligence. It is perhaps because the generic skills associated with communication and administration are easier to standardize, regulate, and discipline than specific skills required for clinical practice (manipulation, prescribing, diagnosis, etc.) that the regulation of the former has assumed considerable significance. However, there is no absolute demarcation between therapeutic practice and such supposedly generic skills as communication. In many areas of CAM, practitioners spend considerable amounts of time speaking with clients to learn about their circumstances and subjective experience. And as Cant and Sharma (1996b) note, it is possible that attempts to standardize this interaction may alienate patients who actively appreciate the individualized nature of the therapeutic encounter. Tellingly, attempts to standardize such aspects of treatment involve a particular construction of patients and their expectations.

The patient should expect to be thoroughly examined, given a diagnosis, realistic prognosis, and a management plan, treated and monitored to ensure the expected progress is taking place and reassessed or referred out if not improving. This should be the

case whatever philosophy the chiropractor uses, and is basically a question of good honest patient care. (Journal of an association of chiropractors, September 2001)

Certain areas are, however, amenable to direct regulation. For example, the Codes of Ethics and Practice adopted by the association of Chinese herbalists dictates that “any form of commercialism in the conduct of a herbal practice is unseemly and undesirable,” and rigidly prescribes advertising communications: “[N]o member may advertise or allow his or her name to be advertised in any way, except in the form laid down by the Council.” Practitioners wishing to publicize a new clinic are restricted to “discreet announcements” in local newspapers, following a set format dictating suitable wording and even the use of bold type. Such announcements must be cleared with the association in advance, and there is a limit on the number of repeat advertisements. Even the size of nameplates is regulated: “Name plates should conform with professional standards and should not exceed 900 cm<sup>2</sup>.”

Standardization thus operates largely on the margins of CAM. The often stringent requirements governing many generic aspects of professional conduct are not matched by similar controls over manipulation, herbal prescribing, or even whether a practitioner should treat a patient in the first place. A suitably qualified practitioner is deemed to be able to reach such decisions in an appropriate way. It is difficult, if not impossible, to determine the average number and frequency of sessions of treatments patients should undergo for any particular condition, but practitioners who have been socialized into ethical practice should be able to reach the appropriate judgement. At the same time, tighter regulation of generic skills affects a form of standardization across a given discipline. In this way, the work of practitioners is made transparent, increasing the accountability of practitioners to a broader range of individuals and organizations. Professionalism thus appears to function as the currency of ‘integrated’ medicine. It allows everything to be exchanged across the decentralized circuits of contemporary healthcare. Yet in becoming transparent (to consumers, other professionals, and regulators), CAM risks simply becoming commensurate with other healthcare professions. In becoming transparent to all and sundry, CAM risks becoming transparent to itself.

## Conclusion

The regulation and professionalization of CAM in the UK reveals a number of significant changes relating not only to the reception of its knowledge claims, but also to the actions of CAM practitioners and their associations:

particularly a new-found emphasis on ‘caring for oneself’ in relation to a collective, impersonal, and idealized subject: the so-called ‘professional’ practitioner. The fact that these changes have generally been embraced and promulgated by practitioner associations suggests that professionalization is best seen as typifying the kind of liberal regulation that arises in response to an underlying sense of ambivalence. This characteristically assumes as its default position the necessity of the implementation of techniques of the self that are “defined by the problem of how free individuals can be governed so that they enact their freedom appropriately” (Rose, 1996, p. 134). What has not previously been fully appreciated, however, is the extent to which the ‘care of the self’ ushered in by regulation and professionalization articulates a very particular spatial expression: the constitution of a self-consciously *national* subject who can be entrusted with the practice of CAM.

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