

Materializing complementary and alternative medicine: aromatherapy, chiropractic, and Chinese herbal medicine in the UK

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Abstract

The paper explores the materiality of complementary and alternative medicine (CAM), with particular reference to aromatherapy, Chinese herbal medicine, and chiropractic, as presented in the journals of UK-based practitioner associations. The paper begins by arguing for a poststructuralist approach to materiality. It then considers how certain materials play a signature (or emblematic) role in the definition and practice of various CAM modalities. Focusing primarily on the examples of essential oils and herbal remedies, we consider how such materials are valued for their agency and expressiveness within the therapeutic encounter. However, these signature materials also possess the ability to produce unwanted effects which regulators, practitioners, and manufacturers seek to control. Consequently, the materialization of CAM is fraught with tension. In addition to these signature materials, the paper also considers the wider assemblage of materials (especially treatment couches) that supplement the taking place of CAM. Although these supplementary materials are often treated in a functional, instrumental, and taken-for-granted manner, these materials are also shown to be duplicitous. The paper concludes by arguing that the continuing professionalization and regulation of the UK CAM sector is radically changing the situated consistency of its signature and supplementary materials.

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1. Introduction

In this paper we consider the materiality of aromatherapy, Chinese herbal medicine, and chiropractic in a UK context. Given the hegemony of a certain constellation of medicine and healthcare within the West (exemplified in the UK by the National Health Service (NHS) and statutorily regulated health professions), other kinds of medicine and healthcare have tended to be referred to as ‘complementary and alternative medicine’ (CAM). Some have been explicitly identified as ‘complementary’ (e.g. aromatherapy, Alexander Technique, reflexology, shiatsu, and meditation), others as

‘alternative’ (e.g. Chinese herbal medicine, Ayurvedic medicine, crystal therapy, dowsing, and radionics), and a select few as more or less ‘mainstream’ (e.g. chiropractic, acupuncture, homeopathy, and osteopathy) (House of Lords, 2000, Section 2.13). Nevertheless, CAM is a very problematic designation, not least because it is negative, static, and dissimulates an enormous range of philosophies and practices (e.g. Ancient wisdom, holistic healthcare, natural medicine, spiritual healing, and unconventional science). These are dynamic forms which cannot be reduced to mere ‘complements’ of or ‘alternatives’ to orthodox Western medicine (Gordon et al., 1998; Kuriyama, 1999; Larderman and Roseman, 1996; Micozzi, 1996; Sharma, 1992). In the UK, for example, chiropractic and osteopathy are statutorily regulated professions informed by clinical research, although they are still not fully integrated into the NHS (either financially or structurally).

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Many more forms of CAM are attempting to follow suit. Indeed, patient-centred, integrated medicine is firmly on the UK agenda (FIM, 1997, 2000; House of Lords, 2000). Meanwhile, it is estimated that CAM in the UK is a rapidly expanding £1.6 billion per annum industry, with around 60,000 practitioners (10,000 of that are statutorily regulated), over 170 professional associations, and around 5 million patients (Budd and Mills, 2000; House of Lords, 2000).

Existing studies of CAM have tended to do one of two things: either they have focused on specific mechanisms of action, such as particular herbal remedies, homeopathic medicines, and essential oils, often with regard to assessing their safety and efficacy (this is especially the case in the clinical literature); or else they have focused on specific CAM modalities, such as herbal medicine, homeopathy, and aromatherapy, as if they were more or less stable, uniform, and constant forms of healthcare practice (this is especially evident in the social-science literature: e.g. Gesler, 1988; Kelner and Wellman, 1997; Williams, 2000). However, there is a world of difference between a fixation on privileged materials on the one hand and a consideration of totalized (and essentially ahistorical and aspatial) therapies on the other hand. This paper attempts to explore that world of difference. It is a world composed of countless materials (from oils and needles to distilleries and manufacturing plants) and innumerable practices (from massage and needling to disciplinary hearings and the campaign for plain English). On each occasion these materials and practices are lent a situated consistency, which is always hesitant and undecidable, principally through the encounters of patients, practitioners, and medicaments in particular socio-spatial settings. Neither CAM nor its constituent modalities exist *as such*. They only exist *in practice*. Accordingly, CAM should not be treated as a catch-all category for what the British Medical Association calls ‘unconventional’ medicine, but as an enigmatic term that poses problems for extant discourses of health and wellbeing. Elsewhere we have analysed the problems posed by CAM within consumer culture and the mass media, and deconstructed both the distinction between orthodox medicine and CAM, and medical and post-medical geography as effective frames of reference for addressing those problems (Doel and Segrott, 2003a,b). Here we restrict ourselves to the materiality of CAM, and particularly the materiality of aromatherapy, Chinese herbal medicine, and chiropractic. What we hope to convey is the extraordinarily rich complexity of their materialization, and especially the way in which each modality can neither be reduced to a privileged material or practice, nor raised to a generic form. To put it bluntly, CAM takes place. Attending to this passing of events requires a very particular kind of materialism, a materialism that is sensitive to singularity (Doel, 1999; Hallward, 2000). The

essence of this materialism is neatly encapsulated in Auster’s (1989, p. 7) demand that “[Y]ou must encounter each thing as if you have never known it before. No matter how many times, it must always be the first time. This is next to impossible, I realize, but it is an absolute rule.” In other words, the materialization of CAM cannot be anticipated. What takes place is always unexpected (Doel, 2004). It is always an event: a singular articulation of heterogeneous materials and practices with a unique consistency that is specific to each encounter. Consequently, if one is to take the materiality of CAM seriously, then one must do much more than take account of the *materials* of CAM. One must also consider the *materialization* of CAM as a succession of singular events.

2. Encountering CAM

It would not be difficult to enumerate the principle materials that various forms of CAM draw upon. For example, chiropractors work with joints, colour therapists with colours, acupuncturists with needles, aromatherapists with essential oils, and Chinese herbalists with herbs. Such signature materials are typically drawn upon to define specific forms of CAM. For instance, in a leaflet prepared for the public by an association of chiropractors, readers are informed that “chiropractors use their hands to adjust the joints of your spine and limbs where signs of restriction in movement are found” (*Chiropractic ... a helping hand*, 2001, unpaginated). However, the materialization of CAM is irreducible to signature materials. For when it comes to materialization, one should always prepare for an unexpected jolt.

Consider five manifestations of CAM: colour therapy, chiropractic, acupuncture, massage, and Chinese herbal medicine. One always encounters much more than a signature material. First, at a ‘Health and Wellbeing’ festival, a few small bottles containing brightly coloured liquids are precisely arranged in tiered arcs on a back-lit table draped in a matt-black cloth. In front of the display a small hand-written label bears the words: Do Not Touch. The woman standing behind the table looks on anxiously, as if she were responsible for the protection of religious icons or aesthetic treasures. Second, the cover of a leaflet entitled ‘*Chiropractic ... a helping hand*’ features nine black-and-white photographs of body parts (a cheek, a neck, shoulders, two backs, an elbow, hands, a knee, and a foot) and a stylized hand-print, the palm of which is rendered as a ‘C’. Third, a web-page contains a few dozen images of the tips of randomly selected mass-produced acupuncture needles photographed via an electron microscope. They reveal innumerable manufacturing faults, including scratches, fractures, deformations, and foreign debris. The accompanying text considers whether the efficacy of

acupuncture depends upon such ‘faults.’ Fourth, an advertising brochure produced by a massage table manufacturer announces that the “soft, supple *Sierra Doeskin*, our standard vinyl, is available in a rainbow of colours. Resistant to abrasions and stains, its super-stable plasticizers withstand oil and mild detergents.” Finally, the *Code of Practice* for an association of Chinese herbalists states: “Direct mail shots and public displays constitute unprofessional activity but discreet display of business cards or similar in health centres or other premises where natural health services are available would be permissible. Name plates should conform with professional standards and should not exceed 900 cm² in size.” These examples demonstrate that if one wishes to take the materiality of CAM seriously, then one will need to appreciate that colour therapy *is also* geometry, that chiropractic *is also* montage, that acupuncture *is also* manufacturing, that massage *is also* upholstery, and that Chinese herbal medicine *is also* business etiquette. In other words, the materiality of CAM is vastly more than the materials of CAM—and these materials and materializations extend far beyond the purview of the medical. CAM is necessarily a de-differentiated field of practice. Its materiality is bereft of taxonomic closure. CAM is transversal. It cuts across every field of practice: medical, social, cultural, political, economic, philosophical, theological, historical, aesthetic, scientific, anthropological, ecological, etc. Consequently, the materiality of CAM cannot be framed in terms of medical geography. No matter how much this sub-discipline is extended and radicalized (into post-medical geography or health geography, for example), it will never be able to take full account of the heterogeneity, de-differentiation, and transversality of CAM (Doel and Segrott, 2003a).

As geographers, we are interested in how disparate materials and materializations can be held together: not in the abstract, but in practice; not as generic forms, but as singular events. This concern for the materialization of healthcare accords not only with the established interest of geographers in therapeutic places and landscapes (e.g. Gesler, 1992; How, 2000; Williams, 1998, 1999;), but also with the increasing interest in embodiment, performance, and ‘lived experience’ that takes its inspiration from poststructuralist and non-representational theoretical practices (e.g. Doel, 1999; EPD, 2000; Thrift, 2000). Importantly, we do not attempt to assess mechanisms of action, efficacy, safety, plausibility or compatibility with other discourses and practices. We are concerned solely with how CAM *takes place*. However, since our research has been primarily with professional associations that represent the interests of practitioners, we have been especially concerned with how these associations have envisioned, materialized, and enacted various forms of CAM. We have not observed the actual interaction between practitioners and

clients. While this is an important limitation it does not detract from the fact that the materialization of CAM takes place in a multiplicity of registers and domains. Our aim is simply to discern the form and character of that multiplicity.

In this paper we focus on the materialization of aromatherapy, Chinese herbal medicine, and chiropractic. This is for three reasons. First, they provide interesting contrasts with respect to their materials, their practice, their history, and their philosophical orientation. Both aromatherapy and Chinese herbal medicine are primarily orientated around the use of a single kind of material (essential oils and herbal remedies, respectively), whereas chiropractic is organized around a wider range of objects. Second, they occupy very different positions with respect to regulatory debates within the UK. Whilst chiropractic has become subject to statutory regulation in the past decade, aromatherapy and herbal medicine are being steered towards this goal via a new-found emphasis on professionalization, unification, and increased self-regulation. These regulatory changes have resulted in a variety of political, educational, and philosophical debates within each modality, all of which have considerable ramifications for their materials and materialization. Finally, CAM in general, and these three modalities in particular, offer a rich context within which to think through the specificity of material geographies.

To address the materiality of aromatherapy, Chinese herbal medicine, and chiropractic as fully as possible we have drawn upon three principal sources: practitioners, suppliers, and regulators. First, we have utilized journals, newsletters, and other documentation produced by UK-based practitioner associations for their respective memberships. Over the period 2001–2003, we have been in receipt of such materials from a range of associations representing practitioners of aromatherapy, Chinese herbal medicine, chiropractic, crystal healing, Feng shui, ‘lay’ homeopathy, medical homeopathy, osteopathy, and radionics. Second, we have referred to a range of advertising materials produced by manufacturers and suppliers of acupuncture equipment, essential oils, herbal remedies, and treatment couches. Third, we have drawn upon documentation produced by governmental agencies that address the materiality of CAM, with particular reference to regulatory interests such as the UK’s Department of Health, the House of Lords Science and Technology Select Committee, and the Medicines Control Agency (MCA). Obviously, the materialization of CAM occurs in very different ways within each of these spaces, and its materials are located within contrasting moral economies (Kopytoff, 1986). For example, a bottle of essential oil may be variously treated as a therapeutic agent, a commodity, a hazardous substance, a sign, a gift or an object that will bring self-empowerment and total wellbeing. Three

methodological consequences follow from this. First, materials only have a situated consistency. They are forever becoming what they will have been (to borrow a Lacanian formulation). If the composition of the situation shifts, then the materials themselves and their materialization as practice will be reconfigured. Consequently, one cannot take the form, function or nature of materials for granted. Second, since we are interested in situated consistency, the crucial thing is not the materials per se, but how they are held together. Third, insofar as situated consistency takes place, it must be grasped as an event. However, since an event is a singularity, it necessarily resists entrainment, structuration, and inscription (cf. Bingham, 1996; Law, 2000; Parkes and Thrift, 1979). This is why we prefer to adopt a poststructuralist rather than an actor-network approach (cf. Deleuze, 1990, 1994; Derrida, 1981; Doel, 2001).

The paper is concerned with three kinds of materials: *signature materials* that are taken to exemplify the specificity of each therapy (e.g. the pure essential oils of aromatherapy, the herbal preparations of Chinese herbal medicine, and the audible adjustment of chiropractic); the *supplementary materials* that are required for each therapy to take place (e.g. a sturdy work surface, a suitable setting, and a range of ancillary equipment); and the *marginalia* that informs and is informed by the therapeutic event (e.g. name-plates, patient records, and dress codes). Accordingly, the next section of the paper explores the way in which certain materials play a signature role in the definition and practice of CAM modalities. Focusing primarily on the example of essential oils, we consider how such materials are valued for their agency and expressiveness within the therapeutic encounter. However, in Section 4 we demonstrate how these signature materials play a duplicitous role in the materialization of CAM because they may also produce unwanted or even deleterious effects which practitioners and regulators seek to control. Section 5 focuses on the wider assemblage of materials and events that supplement the taking place of CAM. Like the signature materials and events, the supplementary ones also turn out to be duplicitous. For example, ostensibly 'functional' materials (such as treatment couches, uniforms, and storage devices) occupy an ambivalent place in the materialization of CAM. Often barely visible in the manifest discourse of practitioner associations and regulatory authorities, these materials are valued for their taken-for-grantedness and lack of expression. Here as elsewhere, however, such materials turn out to be 'dangerous supplements' (Derrida, 1981): their additional support reveals a dissimulated lack within the signature materials. We conclude in Section 6 by arguing that through a new-found emphasis on the marginalia of practice (e.g. advertising etiquette, patient records, and referral procedures), the continuing professionalization and heightened 'regulation at a distance' of the UK

CAM sector is radically changing the situated consistency of both its signature and supplementary materials.

3. Signature materials

Aromatherapy is differentiated from other fields of practice by recourse to its specific materiality. The skillful use of pure essential oils in conjunction with suitable carrier oils for therapeutic purposes distinguishes aromatherapy from other massage-based therapies (which use oil to lubricate physical manipulation) and beauty therapy (which uses cosmetic-grade oils rather than pure essential oils). Indeed, one is struck by the visibility and prevalence of essential oils in the journal of an association of aromatherapists. The front cover typically comprises a full-page, close-up shot of a flower, and each of the quarterly issues is subtitled according to the season of the year (Spring, Summer, Autumn, and Winter) and the stages of essential oil production ('seeding,' 'nurturing,' 'harvesting,' and 'distillation'). Immediately, then, the practice of aromatherapy (and the organization of the journal) is framed explicitly in terms of its materiality. A considerable amount of space is devoted within each issue to the properties, efficacy, and regulation of essential oils. Indeed, the focus upon the materials themselves may sometimes be at the expense of considering how the oils are put into practice on bodies. A respondent to a membership survey held during 2000 felt that within the journal "the massage side of aromatherapy has very little written about it." The report on the survey results noted: "The way in which members read the magazine varies widely . . . but the essential oil profiles appear to be the most popular starting point" (journal of an association of aromatherapists).

Essential oils are highly prized for their therapeutic properties. These oils are central to the therapeutic encounter because they transform bodies, and enable particular kinds of embodied experience to take place. Aromatherapy (like many other forms of CAM) might be thought of as a "program of action" with an associated "*distribution of competencies*" (Latour, 1992, p. 233). Certain tasks are performed by humans (e.g. diagnosis, selection of oils, and massage), while others are 'delegated' to non-humans (e.g. the penetrative ability of carrier oils and the therapeutic powers of essential oils). However, the programme of action is not confined to therapeutic effects, since essential oils (like so many other CAM materials) are valued not only for their capacity to improve health, but also for their expressive qualities and ability to produce particular forms of embodied experience and affect. Through the tactility of massage and the aromas of essential oils, the experience of aromatherapy may become a sensuous, emotional, and even uplifting event in its own right:

hence its appropriation by beauty therapy and its transformation into a pleasurable form of consumption.

Although essential oils are frequently referred to as natural and pure, they are obviously not available as ready-mades. Essential oils are produced through methods of extraction that are appropriate for the specific organic material involved: steam distillation, water distillation, dry distillation, solvent extraction, and cold expression. These modes of production distinguish essential oils from other oils on the one hand, and essences on the other hand. Essential oils result from a physical process of material extraction. Essences result from a transference of energetic structures (taken from objects, animals, environments, etc.) which are imprinted onto water. This transference often entails shamanic rituals. Nevertheless, some aromatherapists also incorporate rituals into their practice. In this paper, we do not pursue the ritual dimension of CAM any further, except to note that it has become a contentious issue in some practitioner associations that are striving for recognition from the medical profession and the Department for Health.

Now, in conjunction with the penetrative qualities of carrier oils, essential oils enter the body and achieve their health effects in ways that can be partly described by recourse to Western science and orthodox medicine. “Oils work by olfaction (smell). The chemicals are taken up by the receptors of the olfactory nerve, transported by the limbic system of the brain to the hypothalamus, from whence they enter the bloodstream” (journal of an association of aromatherapists). However, according to aromatherapists each oil contains innumerable ingredients which in their totality—and *only* in their totality—produce a synergistic effect: the therapeutic power of the pure essential oil is irreducible to its constituent parts. Active ingredients cannot be isolated, standardized or synthesized. Indeed, there are no natural standards for essential oils, only processes of standardization, which are themselves specific forms of adulteration that run alongside contamination by pesticides, fertilizers, weed-killers, colourings, and perfumes, and various forms of rectification and cutting (e.g. removing components to increase solubility; substitution of one essential oil for another, such as Petitgrain for Neroli; using ‘nature identicals’ and synthetic components; and mixing or ‘folding’ different batches of essential oils). Similarly, the toxicity of any one ingredient may be negated (or ‘buffered’) by the presence of other components. The same processes of synergy and buffering also apply when different essential oils are combined.

When they are used by knowledgeable and competent practitioners, essential oils may be presented as natural, safe, and efficacious. Within this generalized mechanism of action, essential oils are framed as materials with specific forms of agency, able to relieve a range of ailments and bring about a transformation in bodily health.

Profiles of individual essential oils (or the plants that produce them) frequently begin by discussing their constitution before opening up to the diverse properties and applications they possess. Clinical case studies also provide detailed accounts of which oils should be administered in response to the symptoms presented by the patient. However, the centrality of essential oils to the coherence and efficacy of aromatherapy is complicated by the natural variations inherent in their production, and their current legal status within the UK. “The Medicines Act clearly states that no medicinal claims can be made on labels, promotional material or advertisements for products that have not been licensed. Essential oils cannot be licensed since they vary like wine, from crop to crop. Therefore no aromatherapy product may make remedial claims if it relates to a specific disease or adverse condition of the body or mind” (ATC, undated).¹ Accordingly, the efficacy of aromatherapy remains essentially undecidable. By definition, a singularity is never repeatable. On each occasion, aromatherapy happens once and for all. Hence the term ‘holistic’ healthcare. Any generalizable claims therefore relate to its virtual powers, and not to its actualization. Healing *may* take place. Whether it *does* take place, however, is a function of the specific encounter between practitioner, patient, and essential oils.

In stark contrast to the way in which aromatherapists exemplify their practice through the active *presence* of essential oils, some other forms of CAM derive their identity through the *absence* of certain materials, particularly an aversion to the signature materials of orthodox medicine (e.g. allopathic drugs, impersonal consultations, and invasive treatments). For example, since chiropractors do not prescribe drugs or use surgical procedures, the introduction of legislation enabling the extension of prescribing rights to UK chiropractors caused one practitioner association some concern: “The [Health and Social Care] Bill... appears to strike at the philosophical heart of chiropractic” (journal of an association of chiropractors). In short, signature materials (e.g. aromatherapy oils) and signature events (e.g. chiropractic adjustments) cannot be taken for granted, since they have to be perpetually enacted and negotiated. As we shall demonstrate more fully below (Section 4), herbs are coming under threat as European regulators become increasingly concerned about the safety of consumers.

4. Duplicitous materials

Essential oils are valorized and given a central significance within aromatherapy due to their agency and

¹ <<http://www.a-t-c.org.uk/>> accessed 30/01/04.

expressiveness. However, like herbs, needles, and other therapeutic materials, essential oils may have unintended and undesirable consequences. They are cumbersome to store, handle, and pour, and are susceptible to degradation, spillage, and staining. The materials used in conjunction with essential oils (couches, towels, uniforms) are thus designed to resist the deleterious effects of oils. For example, Meadow Sweet Oils supplies large platters “designed to protect underlying surfaces from damage through heat or spillages.” Likewise, vapours resist spatial control. “Nurses should re-think the use of electrical vaporizers in wards. These constantly release the aroma of a particular essential oil in an indiscriminate way; everyone on that ward, patients, nurses, doctors, cleaners, visitors experience the smell. . . . A smell that is unasked for and that has unpleasant associations can feel like an invasion of personal space” (Avis, 1999, p. 117).

One of the challenges currently facing practitioners who use plant-based products is ensuring their quality and safety. The need to respond to governmental concern, the prospect of new forms of regulation, and the importance of reassuring growing numbers of actual and potential clients are key issues which practitioners are engaging with. Concerns about the safety of aromatherapy and herbal medicine focus primarily on their material products rather than the competency of bona fide practitioners. As the Aromatherapy Trade Council points out, “The safe usage of essential oils has been the subject of justifiable public concern and has attracted much media attention over recent years. This has meant that the most serious challenge to aromatherapy comes not in the area of its professional practice, but from the retailing market for aromatherapy products” (ATC, 2000). Echoing such sentiments, a Chinese herbalist suggested at his association’s Annual General Meeting that “the profession is being hammered, not because we are bad practitioners but because of poor quality assurance (of our material products).”

Whereas the hostility of biomedicine towards CAM has sometimes been framed in terms of perceived inefficacy, the concerns regarding the safety of herbal medicine acknowledge its power to alter human health. Thus the need for regulation and control (Ernst, 2000; Sharma, 1992). The MCA’s (2002) advice to consumers thus effectively de-differentiates the categories of orthodox and complementary medicine. “Remember that herbal remedies are medicines. As with any other medicine they are likely to have an effect on the body and should be used with care.” In contrast, homeopathy (in which the active ingredient is administered in infinitesimally small doses) is considered by some of its opponents as safe but ineffective, and therefore remains exterior to the orthodoxy. The website ‘Homeowatch’ (a subsidiary of Quackwatch), which provides what it describes as a “sceptical guide to homeopathic history,

theories, and current practices,” claims that “Homeopathic ‘remedies’ are usually harmless, but their associated misbeliefs are not.”² In the discourses of government and in the self-stated aims of regulatory frameworks, it is the safety of CAM which is of key importance, with efficacy, mechanism of action, and plausibility seen as secondary in the drive to protect consumers (Department of Health, 2001). An article in the journal of an association of herbal practitioners discussing the activities of the UK’s Department of Health’s Herbal Medicine Regulation Working Group states: “It should . . . be noted that questions of efficacy are not part of the brief of the DH group: it is concerned solely with questions of competence and safety.”

In July 2002, the MCA produced a report entitled *Safety of Herbal Medicines*, from which we may draw out three key issues. First, the report suggests that certain plant species are intrinsically toxic and therefore inherently dangerous when used to make herbal products. Second, the wide variations present in herbal preparations gives it cause for concern. “Compared with conventional preparations, herbal medicinal products present a number of unique problems when quality aspects are considered. These arise because of the nature of the herbal ingredients, which are complex mixtures of constituents, and it is well documented that levels of plant constituents can vary considerably depending on environmental and genetic factors” (MCA, 2002, p. 18). Third, the way in which herbal products are combined with other materials and particular kinds of bodies is deemed to raise significant safety issues. In particular, interactions between herbal products and orthodox treatments may reduce the efficacy of the latter. Finally, as with allopathic remedies, some forms of herbal medicine are regarded as unsafe for certain groups of people, including pregnant and breast-feeding women, elderly people and children, and people with cardiovascular disease.

For governmental authorities and practitioner associations in particular, the safety concerns outlined above are deemed to require some sort of action, which may be achieved in one of three ways: restricting the availability of the materials themselves; introducing tighter controls over how they are produced; defining who is competent to administer them. The imposition of outright bans on specific herbs (such as Kava Kava), the introduction of voluntary moratoria on the use of others, and the possibility of regulatory action in the future pose acute problems for practitioners. Each prohibition on the use of an individual herb narrows the scope of practice of herbalists, and any widespread controls would threaten the survival and identity of herbal medicine altogether.

² <<http://www.homeowatch.org/>> accessed 30/01/04.

The response of the herbal practitioners to this regulatory climate has been to challenge the rationale of introducing blanket bans on every herb where significant risks to human health are identified. For although herbal remedies may be thought of as having intrinsic properties, their therapeutic powers are actualized through the way in which they are used by a skilled practitioner. A good practitioner should know not only which herb to use (and how), but should also be able to identify high-quality products. If patients typically receive a unique blend of oils or combination of herbs, it is quite possible that, given to another individual, this assemblage of materials might create different or even negative effects. As Kopytoff (1986, p. 75) suggests, such materials might be considered ‘terminal commodities,’ where further commercial exchange or use of the materials is restricted: “the medicine man makes and sells a medicine that is utterly singular since it is efficacious only for the intended patient.” From this point of view, the majority of herbs cannot be considered either safe or dangerous; there are only safe and dangerous ways of producing or using them, each of which is context specific.

“Too many therapists are poorly qualified: they practise other therapies under the name of, rather than as well as, aromatherapy, and they interpret the possible future legislation on essential oils with fear. Some have been taught that essential oils are dangerous; but only lack of knowledge makes them so. An oil labelled ‘dangerous’ can still be used where confidence is assured through knowledge and skill, which unfortunately, many therapists lack. So-called dangerous oils like fennel, sage, nutmeg, etc., because of their very high potency, give beneficial results at the right dose” (journal of an association of aromatherapists).

Professional bodies have therefore sought to defend their herbs, depicting them as precious, vulnerable, and in need of protection from their portrayal as toxic and dangerous by those such as the MCA. “The role of the TMEC [the Traditional Medicines Evaluation Committee] in the next few weeks and months will be to develop detailed monographs in defence of these herbs and to establish itself as a significant consultative body which is available as a resource to the MCA and other government agencies” (Minutes of the Annual General Meeting of an association of Chinese herbalists). For the professional associations, a more appropriate way of increasing the safety of herbal medicine is to regulate who is permitted to administer herbs. The move towards statutory regulation within the herbal medicine sector is supported by such groups partly because it will ensure that only those people who meet certain educational and other professional standards will be able to

administer herbs. A process of professional exclusion is therefore taking place, in which clear boundaries are being formed between qualified practitioners, those individuals deemed incompetent and/or unscrupulous, and the lay public, based on particular forms of knowledge (Cant and Sharma, 1996), much of which relates to the realm of materials.

Another key means by which the safety of herbal medicine is to be improved is through better quality assurance on the part of suppliers and manufacturers, a point on which both governmental agencies and professional bodies share broadly similar views. As well as ensuring that products are not contaminated or adulterated, producers are also urged to provide details of precise ingredients, and full information regarding the origins, production methods, and date of harvest of their herbs. For aromatherapy in particular, the drive to increase standards of production and quality controls is complicated by the fact that essential oils are manufactured for many other end users, many of which do not require pure, organic products. The proliferation of herbal remedies and aromatherapy oils into the world of consumer culture has posed further problems for the regulation of CAM products.

The task of ensuring that only high-quality, authentic materials are used in the practice of CAM is also perceived to be the responsibility of practitioners. At a general level, aromatherapists are encouraged to develop a deep understanding of, and relationship with, their essential oils. “For a complete understanding of essential oils we need to ‘connect’ with the plants from which they are derived. . . . It has occurred to me that, if the only relationship we have with a plant which produces an essential oil is via a liquid in a dark bottle, then that cannot be said to be a *complete* understanding of it, even if we have a reasonable amount of data regarding its use” (journal of an association of aromatherapists). Similarly, a correspondent to a journal of an association of Chinese herbalists critiques the formalization of knowledge that is taking place through the move towards statutory regulation by reasserting the centrality of an experiential knowledge of materials. “Who is an effective practitioner, the person who can recite Bensky [a key text book] or the person who can manage patients in a clinical situation with a good grounding in herbs and the perseverance to research their herbs[?]”

To ensure that they use materials of a suitable quality practitioners are urged to buy from suppliers whose products are correctly labelled, and who are willing to provide detailed information regarding production methods. The quality assurance of essential oils and herbal medicines depends to a large degree on the geographical knowledge which surrounds them. Practitioners are encouraged to garner as much information as possible about where the plants that produced their oils or herbs were grown (which in turn allows

environmental factors to be determined), and their subsequent trajectory through space and time.

“It is of vital importance to check there are no adulterants present or chemical residues of any sort, guaranteeing that the growing of plants is on a certified organic farm. It is also important to have reports of extraction methods, and farming techniques, keeping a close check on the crop quality and harvest over the whole season. . . . To ensure the essential oils you are buying are of the highest quality you need to find a trustworthy supplier who follows certain stringent rules . . . They should have a close relationship with the source i.e. farm and distillers” (journal of an association of aromatherapists).

As Crang (1996, pp. 53–54) suggests, whilst certain consumer products may be sold through the cultivation of “sweeping geographical images which link product to emotion or sensation” (e.g. bath or cosmetic products) here the materials of aromatherapy are given their value by virtue of ‘geographical lores’ which “are more tightly specified, and realist knowledges about commodity production and distribution.” Thus the importance of knowing the exact trajectory of essential oils from field to clinic.

“Know exactly where your lavender essential oil comes from. Our lavender is grown in one place above the village of Marignac-en-Diois in the Drôme. Why should you be concerned about the source? Normally when you buy essential oil, you don’t know its exact provenance. But like wines, essential oils have their own particular characteristics, linked to soils, microclimates, and many other aspects of the local environment. Even the time of day the lavender is harvested and the length of the distillation process play a part. . . . If you buy a litre or more of our oil we can arrange for you, if you are in the area, to visit the field where it was grown.”³

Although practitioners are charged with a large degree of responsibility for ensuring the quality of the oils they use, the ATC also seeks to ensure that its members’ oils are of the necessary quality (through random scientific testing), and assisting Trading Standards Officers to identify aromatherapy products that make misleading claims.

Finally, the duplicitous character of signature materials is clearly apparent when one considers how therapists’ sustained engagement with their own materials may prove deleterious to their own wellbeing. For example, the journal of an association of aromatherapists

cautions that “It is almost inevitable that therapists who are constantly using essential oils may find that they suffer some side effects. These might range from occasional nausea and drowsiness to headaches, fatigue, rashes and eczema. . . . No one really knows what are the long-term effects of continuous exposure to essential oils.” Aromatherapists also risk repetitive strain injury whilst massaging. Similarly, homeopaths have recourse to a remedy that neutralizes the deleterious effects of prolonged proximity to the pills that they supply to their clients.

5. Dangerous supplements

As we have seen, a number of CAM modalities derive their identity and claims for efficacy primarily through the use of a single kind of material product. Essential oils, acupuncture needles, and homeopathic remedies are placed at the heart of the therapeutic encounter, and are central to wider debates about practice, safety, and regulation. The expressive qualities of essential oils and the medicinal power of herbs are harnessed to promote health and wellbeing. However, through their own inherent properties, and the ways in which they are put into circulation, such materials can produce unexpected bodily transformations and unwanted expressions that must sometimes be controlled. Nevertheless, there is a danger in focusing too narrowly on such materials, and thereby reducing acupuncture to its needles, aromatherapy to its essential oils, and Chinese herbal medicine to its herbs. For these materials depend upon a constellation of other objects—a ‘calculus of objects,’ as Baudrillard (1996) aptly puts it—to secure their coherence, maintain their therapeutic powers, and enable them to be put into practice. For example, an essential oil requires a storage vessel, a mechanism for dispensation, hands for application, a carrier oil for penetrating the surface of the skin, and a means of disposing of excess oil from hands, skin, fabrics, etc.

Given their volatility and the ease with which sunlight damages them, essential oils must be stored in opaque glass bottles in order to protect their healing properties. Bottles need to be fitted with droppers, which vary in size according to the relative viscosity of the oils they hold, as well as providing general protection against accidental ingestion. Similarly, homeopathic remedies must be stored and handled extremely carefully so as to avoid damaging their subtle energies. Accordingly, the practice of CAM requires a complex collection of materials over and above the use of oils, needles, pills or treatment machines. For instance, an acupuncture session may rely in equal part upon a desk and chairs, treatment record form, stethoscope, couch and covers, disinfectant, acupuncture needles, clinical waste disposal unit, relaxation music, business cards, and potted plants. The application of essential oils requires oil testers,

³ <<http://www.lavenderfrance.co.uk>> accessed 30/01/04.

carrier oils, a couch, towels, couch covers, and so on, and this wider assemblage of materials allows particular forms of therapeutic encounter and bodily experience to take place. In *Massage World* (2001) (October) a correspondent who is training to be a masseur asks what equipment she is likely to need to buy. The columnist suggests that on top of course fees, a massage student's main costs will relate to the purchase of a massage table, bolsters, couch covers, couch roll, towels, massage oils and cream, uniforms, and assorted text books.

Especially given the individualized, holistic approach of many CAM therapies, each treatment session can require a unique combination of heterogeneous materials. A leaflet produced by the Tawe Homoeopathic Initiative informs the reader that “[W]e treat the person and not the disease. For example, if ten people were suffering from osteoarthritis, it is likely that each patient would receive a different remedy.” The ways in which the body of the patient is situated in relation to waiting rooms, consent forms, diagnostic aids, sets of notes, and soothing music can vary enormously. As with all other forms of practice, the materials utilized within each form of CAM are constantly evolving. New techniques and instruments emerge (such as computerized diagnostic packages and electro-acupuncture), and the development of specialisms has the potential to further increase the diversity of tools used by practitioners. Many practitioners combine therapies (sometimes within the same treatment session) or advocate borrowing certain techniques to enhance the practice of their main modality. Such fusions of practice can lead to seemingly endless combinations of materials. For example, radionics is essentially “the projection of healing energy patterns; to these may be added the wave form of homeopathic remedies, colours, flower essences and herbal extracts if they are indicated as part of treatment.”⁴

Surrounding the use of essential oils and herbal remedies are a range of other materials. Yet despite their importance to the therapeutic encounter, these objects receive far less attention, and are often discussed in a functional, matter-of-fact manner, especially in the journals of practitioner associations. Indeed, the presence of what we might term as ‘functional materials’ is often repressed or at best ambivalent. Especially in the case of those CAM modalities that are not centrally defined through the use of a distinct material (e.g. chiropractic and osteopathy), practice may appear dematerialized. The framing of the couch is an excellent example of such repression and ambivalence. The treatment couch is a central piece of equipment for many CAM modalities. By permitting the body of the patient to be positioned and supported in specific ways, mani-

pulation, massage, and needling are greatly facilitated. The couch may also enable and symbolize different kinds of embodied experiences (e.g. medicalized, relaxing, submissive, and painful). Alongside bottles of essential oils or an array of acupuncture needles, the couch may all-too-easily dominate treatment rooms, potentially over-determining the encounter between patient and practitioner. Despite the insistent presence of the couch, our analysis of the journals of many different practitioner associations reveals not a single article devoted to the purchase or usage of treatment couches. Even the issues of running a practice or arranging the layout of treatment rooms receive very little discussion in the journals, although the tension between commercial self-interest and the altruistic ethos of a caring profession is a recurrent theme.

To rediscover the couch one must look to the advertisements placed in these journals by manufacturers, which in turn provide pathways to a multitude of catalogues and websites. Whereas essential oils, crystals, and needles are valued for their agency and expressiveness, the couch is primarily promoted as a lifeless object whose centrality to the therapeutic encounter is reduced to that of an almost imperceptible presence. Above all, the couch is valued for its functional qualities. It should be strong, stable, and able to support the weight of human bodies without moving or collapsing. “Normally, if the couch is measured correctly, it will account for 90–95% of the body sizes you are likely to encounter. . . . Marshcouches do not rattle, squeak, rock or collapse unexpectedly, unlike some other couches on the market” (Marshcouch brochure). Good couches are quiet and allow the most vigorous massage to take place without interruption. They efface themselves in order to facilitate the taking place of a signature event (e.g. a chiropractic adjustment or an aromatherapy massage).

In selecting treatment couches the Manchester School of Massage describes how “The main features we were looking for . . . [were] that it would be sturdy and quiet to use even under heavy use. After trying various other makes and designs we found that many straight legged massage couches would start to rock and squeak after a certain amount of use, especially those with aluminium legs.”⁵ Or again: “All [Unicouch] couches are squeak free, have anti-collapse security locks, chunky leather carrying handles, comfortable face shaped face holes. All these attributes afford you a personal touch with your patient.”⁶ Through its dependability, stability, quietness, and ease of assembly, disassembly, and transportation, the couch demands little attention. Likewise, other ‘functional’ materials are valued because they demand

⁴ <<http://www.lightparty.com/Health/Radionics.html>> accessed 30/01/04.

⁵ <<http://www.theschoolofmassage.co.uk/treatment-couches.htm>> accessed 30/01/04.

⁶ <<http://www.unicouch.com/>> accessed 30/01/04.

minimal attention, are easy to use, aid the efficiency of practice, and do not express themselves in unexpected or undesirable ways. An advert for Russell Medical's Medipin acupuncture needle describes it as "The new standard instrument for cutaneous sensitivity offering: Superior accuracy, Advanced infection control, Precision handling and efficiency, Eminent disposability, Unrivalled convenience." The functional materials of CAM are akin to the door has been fitted with an automatic opening and closing device, so eloquently described by Latour: "We did not want ever to have to think about this door again—apart from regularly scheduled maintenance (which is another way of saying that we did not have to bother about it)" (Latour, 1992, p. 235).

However, this is not to say that functional materials, like their expressive counterparts, do not need attention or thought. As an advert for Plinth couches declares, "contrary to what some other companies would have you believe not all couches are equal." The practitioner needs to choose from a vast array of couches produced for specific therapies or forms of massage. Couches also vary according to the intensity of massage they are designed for, ease of (dis)assembly and transportation, the provision of optional extras such as face holes and head rests, and the level of patient comfort. The sensuous qualities frequently celebrated in essential oils can also be glimpsed occasionally in the promotion of couches, including their form, colour, and professional appearance. "When my couch arrived I could not believe how BEAUTIFUL it was! . . . Clients love it! The cushioning is deep and supportive and it is as solid as a rock. I like the professional image it presents" (Athena Ryan, student, Darley Therapy Equipment Brochure). Similarly, carrying cases for essential oils can be transformed from functional servants into symbols of professional status or even gifts. Essential Oil Direct's 'student and home use carrying case' promises to be "excellent as a storage or carrying medium." Meanwhile, the 'six-hole minibox' can be used "to send oils to a friend or loved one as a delightful gift," while the 'practitioner case' is "a must for any qualified aromatherapist or advanced student wishing to promote a professional image." In general though, functional materials such as the couch are viewed not as objects that perform active or expressive work, but as a silent, undemanding infrastructure that allows the therapeutic encounter to take place via the potential of oils, needles and massage. Nevertheless, since these supplementary materials must participate alongside the signature materials for the therapeutic event to take place, each is relativized in relation to the other.

6. Marginalia

By way of conclusion we want to demonstrate how the increasing professionalization and regulation of

CAM is impacting greatly upon its materiality. In particular, a process of inversion is occurring, whereby supposedly 'functional,' 'marginal,' and 'unobtrusive' materials such as couches, patient records, name plates, and magazines in the waiting room are becoming central to the formation of professionalized, statutorily regulated forms of practice.

Although the statutory regulation of CAM modalities such as chiropractic involves greater accountability and new forms of control, it also seeks to preserve the clinical autonomy of practitioners and their freedom to choose the most appropriate treatment for each patient. This is especially important given the holistic, individualized emphasis of many CAM modalities, which we discussed above. The expertise involved in selecting essential oils for massage or determining where to place acupuncture needles on the body cannot be distilled into a standardized repertoire of practice. The art of homeopathic prescribing, for instance, might be thought of as "a very concrete and uncodifiable form of knowledge which is acquired by practice itself, and if you do not practice then you do not acquire it" (Cant and Sharma, 1996, p. 582). Similarly, determining the number of treatments required or deciding under what circumstances a patient should be referred to another healthcare professional rely on the situated knowledge of practitioners themselves. Equally, it is difficult for regulatory authorities to provide standard, comprehensive guidelines on the use of such materials as acupuncture needles, herbal remedies and essential oils, when their safety or danger is context specific, depending as much upon the way in which they are utilized as it does upon their chemical composition. Hence the importance of practitioners' skills in locating suitable suppliers, recognising poor quality herbs, understanding how different medicines interact, and which remedies can be safely and effectively used for each individual patient. For instance, the journal of an association of Chinese herbalists tells its members: "It is a world . . . where there are few standards set on the manufacture of products and the practitioner has as much work to do as the manufacturer to improve their understanding of the production and administration of herbal products and not simply follow manufacturers' recommendations."

As Fournier (1999) suggests, however, the proffering of autonomy to increasing numbers of workers creates a discretionary gap that must be managed. Despite its acceptance of the need for certain forms of autonomy, statutory regulation seeks to impose various forms of accountability, standardization, and control. To this end, professionalization is used as a 'disciplinary mechanism' to govern clinical autonomy *at a distance* (Fournier, 1999). Professionalization does not regulate or dictate how individual clinical tasks should be performed. Instead, it emphasizes two things: the need for practitioners to acknowledge the *limits* of their competency (hence the

importance of referral procedures); and the need for practitioners to embrace and perform a *generalizable* work identity (hence the importance of transparency in practice). Consequently, professionalization relies on technologies of the self: the practitioner who has been properly socialized can be expected to undertake each aspect of their clinical work in a professional and competent manner, thus negating the need for regulatory authorities to monitor every individual task.

This emphasis upon a broader, all-encompassing notion of professionalism places a large measure of importance upon a wide set of skills. Of course, a professional osteopath is expected to treat patients competently and safely, but they must also know how to market their practice to potential clients in a professional manner, know how to communicate with patients in a professional way, and undertake ‘continuing professional development’ (CPD). The model of the professional practitioner (who approaches *all* tasks in a professional manner) translates into a concern for the conduct of non-clinical activities, drawing a whole range of supposedly functional, matter-of-fact materials into the purview of professionalization and regulation. Paying detailed attention to advertising leaflets, appointment cards, and CPD record sheets takes on a new significance in the drive to become professional. Being professional involves attending to the patients’ overall therapeutic experience, and not only to whether treatment works safely and effectively. The ambience and layout of the therapist’s work space is considered by practitioner associations to be a key factor in presenting a professional image and creating a positive therapeutic encounter. For instance, osteopaths are informed that “Plenty of anthropological studies of this vital space [the waiting room] have been conducted over the decades, which highlight its importance to the clinical encounter” (journal of an association of osteopaths.). Similarly, a promotion pack produced by an association of chiropractors asks inquiringly: “Is your clinic a good reflection of the high standards of quality chiropractic care you offer? . . . [Y]our patients will notice the way your clinic is run. The following ideas may start you thinking about how to ensure that you give them a quality message from the minute they walk through the door: Scrupulous cleanliness throughout[;] Qualification certificates framed and well-displayed[;] Appropriate, ergonomic seating[;] Warm comfortable surroundings[;] Staff Uniforms.” Similar advice for aromatherapists also emphasizes the importance of the practitioner in creating a professional and pleasing image. “Make sure your product, you, is of the highest quality. Are your skills really honed? Are the couch, towels, and treatment room of the highest quality? Is our appearance immaculate and the way we approach people and communicate warm yet professional, welcoming, reassuring and assertive? . . . [I]s the environment right, does it have the

right ambience?” (journal of an association of aromatherapists). Aromatherapy may represent, in Crang’s (1996, p. 56) terms, a situation “where subjects are not just deliverers of or accessories to the consumed object but part of the product to be consumed.”

Given the difficulties of imposing uniform standards on the slippery world of oils and herbs (not least because it would be inimical to their natural variations), and the need to preserve the clinical autonomy of practitioners, regulation must look elsewhere to achieve standardization, predictability, and control. The answer (at least in part) has been to standardize and regulate the marginalia of practice: the non-clinical, generic tasks that all practitioners undertake, such as advertising, note taking, complaints procedures, and maintaining the physical fabric of clinics. Regulations concerning the safety of couches and other furniture, the design of promotional material, and procedures for informed consent and patient referral are relatively easy to standardize (through codes of conduct and ethics, for example) and reasonably straightforward to enforce (through disciplinary mechanisms and sanctions). In the process, the repressed functional materials of CAM are transformed: they take their place at the heart of regulated, professionalized practice and demand to be taken seriously. Name plates, squeak-free couches, and potted plants can no longer be taken for granted. At the same time, the heightened attention that regulation demands of these materials transforms the practice of CAM, effectively liquidating it. The emphasis upon a very broad version of professionalism (which stresses generic skills such as communication, note-taking, and business etiquette) creates standardization and commensurability between different forms of CAM, and healthcare providers more generally. However, the notion that we are witnessing the regulation of the field of CAM in general or specific CAM modalities such as chiropractic and osteopathy is to some extent mistaken. Regulation is not preoccupied with particular therapies per se or their signature materials. Rather, it is concerned with individual material practices: the objects that are drawn into practice and the ways in which they are put to work. In other words, the processes of professionalization and regulation return us to the marginalia and materialism of the event.

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