The Professionalisation of Complementary and Alternative Medicine (CAM): Competing Knowledges in Practice

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Abstract: This paper provides a sociological account of various knowledges that constitute the professional practice of complementary and alternative medicine (CAM) in Australia. The analysis is derived from interviews with some eleven CAM practitioners in the Sydney and Hunter regions of New South Wales (NSW) and is part of an ongoing study into the use of CAM. The interviews reveal competing constructs from the practitioners such as the constitution of professional knowledge for naturopathy, and the advancement of a western style model of professional practice. These constructs reflect a Western cultural perspective on the therapeutic nature of CAM, and are embedded in a discourse on lifestylism. Overall, there are marginalisation discourses in an industry which, itself, feels marginalised from the mainstream health care sector. In an effort to be part of the mainstream system, some practitioners interviewed appropriate a medicalised discourse. Others are concerned that the move to professionalism may diminish the boundary between the holistic and biomedical philosophies. In conclusion, some of the participants in this study showed that while there are significant epistemological differences between CAM therapies, there is a general agreement on the benefits of increased professionalisation and regulation in this area.

Introduction

Complementary and alternative medicine (CAM) is now a major part of health care systems in post-industrial countries. In 2003, the Federal Government invited an expert committee on complementary health care to recommend regulatory reforms for the sector (Expert Committee on Complementary Medicines in the Health System 2004:132). The committee recommended a co-regulatory model for the regulation of CAM practitioners, who currently operate in a model of voluntary self-regulation. The regulatory reforms have encouraged increased membership of professional associations and organisations. The largest of these – the Australian Traditional Medicine Society (ATMS) – claims to represent 65 per cent of CAM practitioners, and has over 9 000 members (ATMS
Membership Directory 2002:1). Yet, with over 100 organisations in Australia that represent CAM practitioners (Expert Committee on Complementary Medicines in the Health System 2004:125), CAM practitioners do not operate as a unified whole.

As Saks (2004:230) points out, there are significant variations in the principles and practices of CAM practitioners. As professionalisation proceeds, the knowledge base of some practitioner groups is shifting as certain practices and principles are favoured over others. This process by which professional groups harness their knowledge is referred to by Cant (1996:57) as ‘boundary construction’. As the professionalisation of CAM continues, what do certain groups of practitioners regard as appropriate knowledge for practice? What are the emerging discourses on best practice for these groups? Through exploring the boundary constructions of a relatively well organised group of ATMS members, the paper will contribute to our understanding of versions of professional practice in this growing health care sector.

Methodology

A sample of CAM practitioners were interviewed as part of a PhD study on the social construction of CAM use. Some eleven CAM practitioners from the Sydney and Hunter regions were systematically selected (every 40th person) from the ATMS membership directory. Members of this formalised professional organisation are relatively well trained, and are regularly informed of current developments in CAM. As such, this sample is likely to be more favourably disposed toward increased professionalisation than less formalised practitioners. The regions were chosen for their contrasting populations, with the Hunter considered a largely working class population and Sydney the more
international, culturally diverse centre. Taped, in-depth interviews using a semi-structured interview guide were conducted by the researcher between January and May 2004, and transcribed in accordance with University of Newcastle ethics protocols. The interviews canvassed such topics as the place of complementary and alternative medicine in conventional medicine, the individual practice of complementary and alternative medicine and the move to further professionalise the industry in Australia. Specifically, the study participants comprised of:

Four naturopaths (practising a combination of Western herbalism, nutrition, Bach flowers, massage, iridology and some homeopathy)

Two homeopaths

A reflexologist

A kinesiology

An aroma therapist

An acupuncturist, traditional Chinese medicine (TCM) and natural fertility specialist

A hypnotherapist

The Professionalisation of CAM in Australia

The study participants are a well educated group, with some having five to seven years of training. Many hold diplomas from specialist training colleges, and others have university degrees in health sciences or related disciplines. Despite this, they feel they are generally less respected than general practitioners (GPs), and that people have limited awareness of what they do:

…there are some people who surprise me, they walk in here thinking this is great, not what I expected…society still places it at that level. It’s a
matter of education, to make people more aware, and lessen that stigma (Naturopath, Hunter).

There is clearly a strong sense of belief from these practitioners in the integrity of their practice, and the credibility of their profession. Yet, they feel that powerful elites like the Australian Medical Association (AMA) create and dominate the discourse on health and medicine. For example, one participant notes:

if you took society as a whole, [naturopaths are not respected] because you have the power of the AMA, if you look at the pharmaceutical industry, they are in the top 10 of the most powerful industries in the world (Naturopath, Sydney).

These groups have power, wealth and centralised organisation, while the CAM sector is an alternative minority, decentralised, with fewer policies or funding. The participants in this study are aware of the effect of the dominant medical discourse on public health knowledge, and they are eager to advance the public knowledge on complementary health practice and philosophies. Ultimately, they see this as a function of increased professionalisation. For this reason, the majority support regulatory reform:

I like the fact that I’m regulated, that I’m inspected...There are people standing behind me saying ‘whatever qualification she gives is good enough’. That I can have a relationship with a government university that also recognises what we do. And that there are standards upheld, especially within the medical sciences (Homeopath, Sydney).

However, they are also sceptical of the government’s agenda. They see the Federal Government inquiry into CAM as stacked with members of the power elites. They feel they may be excluded from the regulatory process, as evidenced in this quote:
The problem is when you get regulation externally; they start to apply too many external situations. Non-hypnotherapists are basically causing problems which shouldn’t exist...if there were a regulatory board, who are they going to put on it? [Participant] doesn’t have a university degree...so you’re not getting the true hypnotherapist (Hypnotherapist, Sydney).

Mike Saks has written extensively on the professionalisation of complementary medicine in the UK. Saks (2003:104) proposes that, for CAM practitioners, professionalisation is a means to shedding the stigmatising labels of the past. Practitioners on the whole are sensitive to the derogatory labels of ‘quacks’, ‘snake oil salesmen’ and the like, and are eager to dispel these images. These derogatory terms are mentioned often in the interviews, and the study participants are keen to shift the stigma. For example, one participant proposed that:

It [professionalisation] takes out the alternative...or eccentric old man or woman, it really establishes a level of professionalism for the industry and associated us with fundamental health care, not whacky type stuff (Naturopath, Sydney).

Thus, professionalisation is also linked to respect and credibility. The practitioners are especially sensitive to such images since the 2003 Pan pharmaceutical event, where the media shifted the focus from the regulatory practices of a pharmaceutical company to the efficacy and credibility of the complementary health sector. The CAM practitioners equate professionalisation with a regulatory practice model, a certain level of educational qualifications and standardised practice regimes. When one considers the effect of regulation on the conventional medical profession, there are obvious similarities to the current situation for CAM. As Dew argues (2004:64), increasing forms of regulation are
progressively leading to the standardisation of CAM, and the relationship between
regulation and notions of science is critical to this standardisation process.

Some see the growing use of CAM as reflecting a discourse of individuality, which
situates the individual as central to the healing process, and exercising control of mind,
body and spirit (Hughes, 2004:33). For the study participants, the holistic paradigm is the
unifying principle of CAM which underlies the practice of complementary health care.
As defined by a participant, holism is:

Treating the whole person, whether it be physical, mental or emotional in
approach. For example, a person...has irritable bowel syndrome..., and
sure that’s a physical symptom but what’s causing it...could be stress,
could be emotional drain...From a holistic point, that’s what we tend to do
(Naturopath, Sydney).

Of interest here is the extent to which these participants employ a rhetoric on
individualism (involving regimentation and discipline) which appears to empower a
client, but also subjugates them (in a similar way to medical surveillance). Braathen
(1996:157) sees this as a new kind of medical surveillance in which CAM practitioners
are agents for self-disciplining technologies. The surveillance requires a disciplined
regime of dietary and other lifestyle changes. It can be likened to Foucault’s (1972:43)
‘cultivation of the self’, in which the individual cultivates their mind or body in a
disciplined, regimented way. The participants link the concept of self-responsibility to
empowerment, and the phrase ‘take the stand for your health’ is used by several
participants. Participants expect their clients to benefit from CAM, and to experience
similar non-specific effects. Thus there is a paradox of individualism, or the adoption of
individual approaches to clients, with the expectation that they will all receive similar benefits or outcomes.

In regard to professionalisation, some participants sense that the principles of holism could be undermined by those of biomedicine. The appropriation of CAM knowledge by orthodox medicine is not new (see Lupton 2003:137; Cant 1996:56; Willis and White 2004:55). For example, Cant (1996:56) provides a fascinating historical account of how British homoeopathy achieved professional legitimacy through an alignment with the scientific biomedical discourse. The appropriation of a medicalised knowledge base was not accepted by the homeopaths that favoured an esoteric knowledge base (Sharma 1996:177). The resulting medicalised discourse in homeopathy is evidenced through the use of scientific discourse:

In the past, our profession was considered to be airy fairy, because we are dynamic, because we work with energy, it is open to misinterpretation. However, as time goes by and technology improves there are quantum physicists who come up with the answers as to how homeopathy works. (Homeopath, Sydney)

The homeopaths in the study are protective of their knowledge, and express concern over the inappropriate use of homeopathic medicine by naturopaths, and others with minimal training in homeopathics. Including homeopathic units in a natural therapies curriculum (eg. Australian Natural Therapies College Prospectus 2004) has resulted in naturopaths offering homoeopathic treatments. For example, a participant with natural therapies training who identifies as a homeopath, observed that:
They [homoeopaths] are only trained to get the symptoms to match those symptoms with a specific remedy, whereas what I do is such a complex thing … so I do give nutritional supplementation and herbs which is bordering on to being a naturopath … I guess I say I’m a homeopath, nutrition and do bodywork as well. For someone who has absolutely no idea, I would just say a naturopath, because a naturopath covers everything (Homoeopath, Sydney).

This quote suggests that there are contested boundaries of what constitute professional knowledge for certain CAM modalities. It also raises issues for the clarification of professional titles, and the expectation that consumers have of those professionals.

Another interesting construct to emerge from the study is the advancement of a ‘best practice’ model in CAM based on a communication based, counselling style relationship with the client (Sharma 1996:177). This style is seen as pivotal to developing a trusting relationship with the client, and providing the means for an individualised treatment regime. This style of practice is common to ‘Western’ modalities, and is taught in many training colleges. There appears to be no uniform term to describe this principle of CAM practice. However, certain authorities identify characteristics of CAM which incorporate it such as ‘humanism’ (Coulter 2004:113) or Sharma’s (1996:17) reference to ‘therapeutic knowledge’.

Positioned against this consultative style is that which has limited verbal engagement with the client, such as Traditional Chinese Medicine (TCM). There appears to be a strong ethnocentric bias in this discourse, as evidenced in the following quote:
The other thing that worries me is these quick fix little centres at the shopping centres these little Chinese men, they don’t ask any questions, they go in there hammer and tongs, fist and thumbs, they don’t know if people have surgical problems or diseases… you’ve got all these people who have nobody looking at what they’re doing at all. I went to one just to see how they went and he nearly killed me, I was in pain. And I said to all my clients, ‘please, don’t ever go to those places’. Absolutely dangerous. (Reflexologist, Sydney).

The quote suggests that practitioners that do not incorporate a strong consultative focus are unprofessional. Another related construct is the application of a model of care which involves pampering, relaxation and the minimisation of pain. In line with the ‘lifestyle’ discourse (Coulter 2004:117), the approach encourages practitioners to treat their clients well. Again, this is positioned against CAM practices that involve pain such as TCM.

**Conclusion**

This paper has explored the boundary construction and professionalisation processes of a relatively well organized group of ATMS members, using interviews with practitioners as the means for the exploration. There are clearly marginalisation discourses in an industry which, itself, feels marginalised from the mainstream health care sector. The ‘Western’ distrust of certain practices may result in the censure of some practitioners from professional development, including belonging to certain professional organisations. Saks (2000:124) discusses this sort of exclusion as a by product of professionalisation, which ultimately seeks to enhance the power of practitioners via a standardised knowledge base.

Four themes can be drawn from the analysis of this paper. First is the issue of professional boundaries for professionalised knowledge. Specifically practitioners of the
discipline of homeopathy expressed concern about naturopaths practicing homeopathy, as
naturopaths are not trained this discipline. We might conclude here that boundary
disputes in CAM are not dissimilar to those found in any area of health or indeed
professional service delivery. The second theme relates to the adoption of a western style,
consultation/counselling model being adopted as the best practice model for CAM
consultations. The adoption of this model suggests the advancement of a western style
model of professionalisation. A third theme concerns the minimisation of pain as
important to the process of applying CAM to clients :(lifestyle discourse). This approach
appears to position CAM in relation to traditional Chinese medicine massage which in
some instances involves pain. Fourth there is the paradox of individualism, or the
adoption of individual approaches to clients, however with the expectation that they will
all receive similar benefits or outcomes. There was a tendency for some of the
naturopaths interviewed in this study to think in this way, but without any clear trend
being evident. In conclusion, some of the participants in this study showed that while
there are significant epistemological differences between CAM therapies, there is a
general agreement on the benefits of increased professionalisation and regulation in this
area.

References
College of Natural Therapies


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FOOTNOTES

1 In 2000, MacLennan (2002:1) calculated a national expenditure on CAM of $2.3 billion, and some 52 percent of Australians had used CAM in the last 12 months. For this paper, CAM includes homoeopathy, naturopathy, acupuncture, aromatherapy, herbalism (Chinese and Western), Reiki/energy, hypnotherapy, physiotherapy, massage, aqua therapy, osteopathy and reflexology. The term also includes medicines such
as vitamins, bach flowers, herbs, protein powders, antioxidants and similar. Australians tend to favour the use of naturopathy and are increasing their use of aroma therapists, reflexologists, acupuncturists and herbalists (Bensoussan et al, 2003:17).