The holistic discourse and formalising education of non-medically qualified acupuncturists and homeopaths in England: An in depth, qualitative study

Assaf Givati

This thesis is submitted in partial fulfillment of the requirements for the award of the degree of Doctor of Philosophy of the University of Portsmouth.

School of Health Sciences & Social Work

University of Portsmouth

March 2012

Abstract:

The 'holistic discourse' is a central identification mark of acupuncture and homeopathy practice. The term holism reflects much of the critique of biomedicine as reductionist, dualistic and oppressive, and, as such, has been used to distance these therapies from conventional medicine. However, in recent years, acupuncturists and homeopaths in the UK have become increasingly engaged in professionalisation, including the formalisation of their education. These efforts to move closer to the mainstream call into question the role of holism in the representation of acupuncture and homeopathy practice.

The overarching aim of this research study is to explore the way that Non Medically Qualified (NMQ) acupuncturists and homeopaths in England, as part of their efforts to professionalise and formalise their educational structures, negotiate holistic concepts that are embedded in their theory, practice and discourses. The thesis firstly considers the meanings that the two practitioner groups attach to the rather fluid concept of 'holism'. It then moves on to examine how the holistic discourse is negotiated during the process of formalising education including the teaching of courses in Higher Education Institutions (HEIs).

The thesis is the product of an in-depth, qualitative inquiry. Several data sets were used in this research: (1) Twenty-five in-depth interviews with acupuncturists and homeopaths in London and the South of England, including practitioners who are school principals and lecturers; (2) Participant observation of teaching a research methods unit in a BSc (Hons) Acupuncture in a private school for Chinese medicine; (3) A review of practitioners' professional websites, of professional bodies' educational and practice documents, and of 27 acupuncture and homeopathy course syllabi; and (4) Two non-participant observations of a day in an acupuncture practice and a day in a homeopathy practice.

The findings from this research study show that NMQ acupuncturists and homeopaths still make frequent use of the term 'holism' as part of the representation of their practice. Nevertheless, their holistic discourse appears to be mostly focused on individuals and their immediate environment, a discourse which can be described as 'wider self' holism, with little awareness of the relationships of patients with their broad environment, these relationships being described as 'wider world' holism. Crucially, the holistic discourse which is interwoven in acupuncture and homeopathy's philosophy, theory and practice, is a dynamic discourse, influenced by political and societal factors surrounding these therapies, as well as by the dynamics within the therapies themselves. This research study demonstrates the way practitioners *'narrow'* and *'expand'* their holistic narratives and practices according to the challenges that they face during the process of

professionalising and formalising their education, as well as in relation to their consumers' expectations. This research study suggests that the way by which practitioners often negotiate the tension that exists between increasing formalisation and the unique nature of their expert knowledge, can be described as *'pragmatic holism'* through which practitioners try and make gains from the formalisation process, without losing their holistic approach and appeal. Furthermore, the entrance of HEIs to the teaching of acupuncture and homeopathy courses seems to have accentuated some of the tensions that are part of the formalisation process, but it may also offer opportunities to increase practitioners' critical reflectivity in relation to their holistic discourses and practices and to expand their wider world holistic awareness.

Contents

While registered as a candidate for the above degree, I have not been registered for any other research award. The results and conclusions embodied in this thesis are the work of the named candidate and have not been submitted for any other academic award.

Signature:

Table of figures

Table of tables

Abbreviations used in this thesis:

AACP	Acupuncture Association of Chartered Physiotherapists
BAAB	British Acupuncture Accreditation Board
BAcC	British Acupuncture Council
CAM	Complementary and Alternative Medicine
FoH	Faculty of Homeopathy
HEIs	Higher Education Institutions
HESA	Higher Education Statistics Agency
HPC	Health Professions Council
NMQ	Non Medically Qualified
NOS	National Occupational Standards
SoH	Society of Homeopaths
TCM	Traditional Chinese Medicine
UCAS	Universities & Colleges Admissions Service
WHO	World Health Organisation

To my parents, Yoav and Roni Givati, for everything...

Acknowledgements

I am grateful to all the all people who supported me throughout this process. Without them I would not have been able to complete this journey. Thank you to both my supervisors, to Dr Ann Dewey for pushing me all the way, and to Dr Kieron Hatton for his encouragement, support and insightful comments. A big thank you to all of the study participants for their friendliness, their hospitality, for letting me into their world, for making time to talk to me and for sharing their views and experiences with me. Thank you to my friends and colleagues in our lively, open plan office of Healthcare Science for their ongoing support and for absorbing my increasingly frequent outbursts of frustration. I could not have asked for nicer colleagues to be surrounded by.

Thank you to the School of Health Sciences and Social Work, University of Portsmouth, for supporting this study. I would like to thank the following people for their help and advice in different stages of the process: to Dr Joana Almeida for her support and for her valuable comments, to Sarah Treloar for proofreading my work and to Professor Tara Dean for her comments on the final draft of this thesis. Thank you to Dr Sheelagh Campbell, Dr Guy Van de Walle, Dr Faith Hill, Professor George Lewith, Dr Pam Schickler and Dr Yohai Hakak.

I would like to express my deepest gratitude to my family, aba Yoav, ima Roni, and my sisters, Orit and Namic, for all their support from the distant warmth of Ein Gedi and Israel; to saba Shaul, and to uncle Ilan. Most of all, I would like to thank Janine, for all of her support, warmth, wise advice and constant encouragement. I could not have done it without you.

Chapter 1

Introduction

This thesis firstly considers the meanings that Non-Medically Qualified (NMQ) acupuncturists and homeopaths in England, their schools and professional bodies, attach to the rather fluid concept of 'holism' as a main identification mark of their practice. It then moves on to examine how acupuncture and homeopathy's holistic discourse is negotiated during the process of formalising the therapies' educational structures, including the teaching of courses in Higher Education Institutions (HEIs). In this introductory chapter I will describe the setting against which this research has been conducted and the context in which my research questions are nested.

The thesis is the product of an in-depth, qualitative inquiry. Several data sets were used in this research: (1) Twenty-five *in-depth interviews* with acupuncturists and homeopaths in London and the South of England, including practitioners who are school principals and lecturers; (2) *Participant observation* of teaching a research methods unit in a BSc (Hons) Acupuncture in a private school for Chinese medicine; (3) A *review of documents* including practitioners' professional websites, of professional bodies' educational and practice documents, and of 27 course syllabi; and (4) Two non-participant observations of a day in an acupuncture practice and a day in a homeopathy practice.

1.1 Research questions

The overarching aim of this research is to explore the way that NMQ acupuncturists and homeopaths in England, as part of their efforts to professionalise and formalise their educational structure, negotiate holistic concepts that are embedded in their theory, practice and discourses. The following questions guided the research:

- What are the meanings attached to holism by practitioners, schools and professional bodies of NMQ acupuncturists and homeopaths in England?
- To what extent are NMQ acupuncturists and homeopaths in England reflective in relation to their holistic discourse?
- How do NMQ acupuncturists and homeopaths negotiate the holistic premise of their practice in the course of formalising their educational structures?
- What is the impact of HEIs on acupuncturists and homeopaths' holistic discourse?

1.2 The context of the investigation

Complementary and Alternative Medicine (CAM) is an umbrella term describing a wide range of therapies and practices that are not part of mainstream medical care (House of Lords Science and Technology Committee, 2000). Sociological and historical accounts describe how, after a long period of marginalisation, CAM's popularity re-emerged during the late 1960s as part of a medical counter culture (Crawford, 2006; Goldstein, 1999). A growing unease with certain aspects of conventional medicine and the biomedical model gave rise to various pressure groups from within the healthcare user population, such as a consumer movement, a women's health movement, a self-help movement, and a health promotion movement and with it, 'a culture of fitness', all of which called for a shift of responsibility from professionals to individuals (Crawford, 2006; Goldstein, 2003; Kelner & Wellman, 2003, p. 25). Much of this critique focused on the 'reductionist' and 'oppressive' nature of modern medicine, whilst emphasising the 'holistic' nature of CAM therapies as an increasingly popular alternative (Bates, 2002; Scott, 1999; Rosenberg, 1998, p. 345). Consequently, the term holism is very often used in relation to CAM and is described as a common thread to most CAM therapies (Goldstein, 1999, p.47). According to Oxford Dictionaries holism is

> the theory that parts of a whole are in intimate interconnection, such that they cannot exist independently of the whole, or cannot be understood

> without reference to the whole, which is thus regarded as greater than the sum of its parts . [In relation to] Medicine: the treating of the whole person, taking into account mental and social factors, rather than just the symptoms of a disease.

However, the term holism carries multiple meanings and interpretations without there being a consensus as to its definition (Cant & Sharma, 1999, p. 8; Stone & Katz, 2005, p. 219). Gradually, an emerging literature, which presented challenges and dilemmas inherent in CAM's holistic, anti-reductionist claims, started to emerge (Baer, Hays, McCLendon, McGoldrick & Vespucci, 1998; Baer, 2003; Coward, 1989; Crawford, 2006; Goldstein, 2003; Lowenberg & Davis, 1994; Montgomery, 1993; Salkeld, 2005; Scott, 1999).

The autonomy of medicine and its authority are being questioned by CAM practitioners (Kelner, Wellman, Boon, & Welsh, 2004) and by segments of the public, who are comparing medicine to more holistic and individualised approaches which characterises many CAM (Goldstein, 1999). Sociological accounts describe a growing trend within the past couple of decades of integrating parts of CAM into the mainstream as well as efforts of some CAM to establish formal professional structures. Efforts of some CAM therapies to enter the mainstream and establish clear professional boundaries are described as part of professional closure strategies (Saks, 2001). Social closure refers to the way occupations seek to regulate market conditions in their favour, and thus limit competition from others by employing strategies which restrict access to a limited group (Parkin, 1974). In the context of social closure, professions are occupations with a legal monopoly of social and economic opportunities in the market place which are based on credentialism (Macdonald, 1995). Such strategies in CAM include attempts to formalise and standardise professional knowledge (Clarke, Doel & Sergott, 2004; Saks & Lee-Treweek, 2005, p. 87), which often involve the tempering of holistic knowledge claims, the same claims that contributed to the very rise of CAM as part of the medical counter-culture (Cant, 2009).

Acupuncture and homeopathy are the two most popular CAM therapies in high-income countries (Ong, Bodeker, Grundy, Burford & Shein, 2005, p. 63), and are considered, according to the House of Lords Select Committee (2000) report on

CAM as being among the main five CAM therapies worldwide[1]. Despite their very different origins and history, both therapies challenge the biomedical model in both theory and practice and can be described as 'inherently holistic' (Goldstein, 1999). Like several other CAM, both therapies are engaged in professionalisation efforts, trying to increase their societal status and move closer to mainstream medical care (Saks & Lee-Treweek, 2005). These efforts raise questions in relation to the way that acupuncturists and homeopaths negotiate their holistic discourse that they use as part of their strategy to gain popularity (Keshet, 2009), with the requirement to formalise and standardise their professional knowledge.

I will now turn to describe the field of my research. I will start with a short discussion of CAM's complex definition, followed by a description of its consumption-trends in the UK. I will then provide a short historical context to the (re)emergence of CAM, and I will describe the two therapies that are at the centre of this research, acupuncture and homeopathy. Finally I will outline the structure of this thesis.

1.3 Addition to the current literature

There are several areas in the literature that I aim to contribute to in this thesis.

First, surprisingly under explored is the field of CAM education (Gale, 2007, p.41), and more specifically the journey of CAM into UK academia since the mid-1990s. The relationship between CAM and HEIs in the UK is intrinsic to the therapies' efforts to formalise their educational structures as part of professionalisation strategies and as part of their attempts to increase their mainstream societal status (Clarke et al., 2004). Despite the unique nature of expert knowledge in CAM which makes it difficult to standardise the therapies such as acupuncture and homeopathy (ibid), the way that such knowledge is negotiated during the formalisation of education has been little explored to date. Examining the challenge of formalising education in the CAM context requires a discussion of the

[1] The other three therapies according to the report are chiropractic, osteopathy and medical herbalism.

holistic discourse in CAM, which is central to the therapies' knowledge and practice (Fulder, 1996; Goldstein, 1999). Since holism has many meanings and interpretations (Stone & Katz, 2005, p. 219), it is first essential to explore the holistic discourse of NMQ acupuncturists and homeopaths, and what holistic claims are being made as part of this discourse.

Second, a number of authors discussed potential unintended sensitivities in relation to CAM's holistic discourse (Baer et al., 1998; Baer, 2003; Coward, 1989; Crawford, 2006; Goldstein, 2003; Lowenberg & Davis, 1994; Montgomery, 1993; Salkeld, 2005; Scott, 1999). In particular such sensitivities are part of the holistic-participatory medical encounter in CAM (Gale, 2009). Considering these potential unintended sensitivities and the fluidity of the concept holism, it is useful to explore NMQ acupuncturists and homeopaths awareness and critical reflectivity in relation to their holistic discourses and practices.

Third, the diversity in CAM therapies, and moreover, the diversity of practice-styles within some of the major CAM such as acupuncture and homeopathy, calls for a closer consideration of individual therapies. For example, acupuncture and homeopathy each have a unique philosophical grounding, historical roots, political stature in society, and different relationships with the various actors in the healthcare market. Not only that, as we shall see, both traditional acupuncture and classical homeopathy are sub-divided into schools and styles of practice, each bringing a different type of holistic engagement and perspective. As Sharma (2005) points out, for professional organisations to develop in the first place

> There must be networks of practitioners with established patterns of interaction and some sense of common cause. To develop effective strategies there needs to be some degree of consensus about means and ends, about how members communicate with each other and with agencies outside the profession. i.e., there must be some degree of common political culture, as well as common occupational skills and knowledge (Sharma, 2005, p. 260).

The difficulty with CAM, Sharma argues, is the fact that the diversity of schools and practice styles has a divisive effect on the professional group. For example, the various British Acupuncture Council (BAcC) accredited courses teach differing styles of acupuncture practice, such as 'Traditional Chinese Medicine' (TCM), Five Elements acupuncture, Japanese meridian acupuncture, or the Stems and Branches approach, and each approach has different kind of engagement with holism. The lack of a more in-depth exploration of individual therapies results in a failure to recognise such important 'nuances'.

Fourth, in relation to the therapies holistic discourse, it is important to consider the cultural differences between different geographic settings. For example, much of the critique of CAM's holistic discourse is from North America (Baer et al., 1998; Baer, 2003; Crawford, 2006; Goldstein, 2003; Lowenberg & Davis, 1994; Montgomery, 1993; Salkeld, 2005). The UK offers a unique setting with unique health structure, political culture, and situational relationships of CAM with other important stakeholders such as the scientific and the academic community and the media. Deepening the exploration of this unique 'CAM habitat' and holistic discourse in this particular setting is definitely warranted. Finally, many of the accounts describing the way acupuncturists and homeopaths negotiate the complex relationships between their holistic, anti-reductionist, anti-oppressive discourse, and their efforts to move into the mainstream, are in the context of integrated care settings, in which CAM practitioners work alongside, or often under, the supervision of conventional doctors (Wiese, Oster & Pincombe, 2010). However, most acupuncturists and homeopaths practise outside such settings in their private practice (Thomas & Coleman, 2004), and this domain is not well explored.

Before I continue to present background information that sets the scene for the thesis, I would like to briefly comment on the geographic setting in which this study took place. Although the leading professional bodies of NMQ acupuncturists and homeopaths represent practitioners from the whole of the UK, since my interviews were with practitioners from the South of England, I decided to describe the setting of my research as 'England' rather than 'the UK'.

I will now move on to describe the setting of my research and provide essential background information about CAM in general, and on acupuncture and homeopathy in particular.

1.4 Complementary and Alternative Medicine (CAM)

Complementary and Alternative Medicine (CAM), often described as 'natural medicine', 'non-conventional medicine' or 'holistic medicine', is an extremely diverse group of therapies united by the fact that they are not considered part of mainstream medical care, also referred to as ‘conventional’ or ‘orthodox’ medicine, and often defined as ‘biomedicine’ (House of Lords Science and Technology Committee, 2000; World Health Organisation, 2002, p. 8). According to Saks (2003a, p. 142), conventional medicine includes all forms of medicine that are significantly supported by the state. In contrast, CAM includes therapies that are not typically supported by the state, and are not significantly part of medical education, policy making or research funding. Throughout this thesis I will use the term *Complementary and Alternative Medicine (CAM)* to describe this group of therapies, unless the therapies appear in a historical context, in which case I use the older term *alternative medicine*. At the same time I will use in this thesis the term *conventional medicine* in relation to mainstream medical care, in the context of its political position in society, or *biomedicine* to describe the scientific-dominant nature of mainstream medical care.

I would like to point out the complex nature and my somewhat schematic use of the terms ‘East’ and ‘West’ in relation to the description of biomedicine and of various CAM therapies. While the terms are often used in the literature and are useful in considering the historical roots of biomedicine, acupuncture and homeopathy (for example Bates, 2002), the terms are clearly problematic and politically contested also in the context of CAM’s description and definition. Other terms that are used in the CAM literature are ‘industrial’ countries (for example Boon, Welsh, Kelner & Wellman, 2004), or ‘developing’ and ‘developed’ countries

(for example World Health Organisation, 2002), although arguably, all terms are somewhat problematic.

Biomedicine started to establish itself in 'the West' in the late 1850s with the establishment of the American Medical Association in 1857 and the British Medical Act of 1858 (Saks, 2005a, p. 254; Turner, 2004). This act provided the medical profession with the authority to define medical practice, medical ethics and medical education. Hence, biomedicine became mainstream or 'conventional' medicine. This political and professional organisation of the medical profession in effect led to the creation of 'alternative' medicine, as a group of all therapies that are not part of the newly defined medical profession. Since, most commonly, CAM therapies are defined on the basis of what they are *not* - rather than on the basis of *what they are* - makes it difficult to identify the nature of this group. In its major inquiry into CAM practice in the UK, the House of Lords Select Committee argues that 'the CAM community has been struggling for fifteen years to come up with a single definition of CAM agreed by all, but with no success' (House of Lords Science and Technology Committee, 2000, section 1.13).

There are more than 200 different CAM modalities in the UK alone (Stone & Katz, 2005, p. 33) and it is difficult to identify the characteristics shared among some of them. For example it is difficult to detect commonalities between aromatherapy[2], crystal therapy, yoga, nutritional medicine and chiropractic[3]. It is argued (Coward, 1989; Frohock, 2002) that CAM has been defined in relation to its compatibility or contrast with biomedicine. Several efforts have been made to group CAM therapies into different categories using historical, political, or practice-related perspectives. Cant and Sharma (1999, p. 5) offer a historical point of view, dividing CAM into five categories: therapies such as homeopathy that developed in Europe and in North America prior to, or around the same time as modern biomedicine started emerging; therapies such as chiropractic and osteopathy[4] that

[2] The external use of concentrated essential oils from plants through massage or inhalation (Fulder, 1996).
[3] A technique in which movement and function of the musculoskeletal system is restored, especially between the vertebrae, by means of massage and short sharp thrusts (Fulder, 1996).
[4] A technique in which movement and function of the musculoskeletal system is restored by means of leverage and repeated manual articulation (Fulder, 1996).

originated in the period of medical individualism that characterised healthcare in the US in the late 19th and early 20th century, before the introduction of tighter licensing laws; therapies such as naturopathy[5] originating from health spas in central Europe that flourished in the 19th century; therapies such as acupuncture that re-emerged or were imported to the West from Asia; and finally therapies that have entered Western countries with migrant groups, for example Ayurveda[6] which arrived with Indian migrants.

Another model for grouping CAM is the grouping of therapies by a House of Lords Select Committee for Science and Technology (2000) that made major recommendations in relation to CAM practice in the UK. The committee grouped therapies mainly on the basis of their political status in the UK. The first group, referred to by the committee as 'the big five CAM', includes five therapies that are the *most professionally organised*, including acupuncture and homeopathy. Group two contains therapies such as reflexology[7] or aromatherapy that are used as *complementary* to conventional medicine and are practised alongside it. Group three contains *alternative therapies*. This group is sub-divided into two groups: *long-established and traditional systems of healthcare* such as naturopathy and ayurveda, and a second group which includes *other alternative therapies* such as crystal therapy, arguably the least scientific group. Overall, rather than providing an exact definition of CAM, this grouping was aimed at providing a framework for developing guidelines for CAM practice and utilisation (House of Lords Select Committee, 2000, section 2.1).

With time, despite its diversity, CAM adopted a certain outlook and a certain discourse of its own. This is evident by the way CAM is represented politically and in the way it is described in the literature. Politically, CAM is represented as one group for example, by the UK's Research Council for Complementary Medicine,

[5] The use of a range of natural approaches including diet, herbal medicine, water cure, and encouraging exposure to sun and fresh air to maximise the body's own healing capacity and natural responses.
[6] An aggregation of medical practices based on ancient Vedic texts in India, based on a unique and overarching life-philosophy. In practice includes manual manipulations, yoga, herbal medicine and diet (Fulder, 1996).
[7] Massage of areas of the feet to treat organ systems with which they are in developmental and energetic relationship (Fulder, 1996).

the US National Centre for Complementary and Alternative Medicine, or the European Federation for Complementary and Alternative Medicine. There is extensive literature referring to CAM as a cohesive group (for example Adams and Tovey, 2008; Fulder, 1996; Heller, Lee-Treweek, Katz, Stone and Spurr, 2005; Kelner and Wellman, 2003; Micozzi, 2006; Vickers, 1998), and there is significant number of peer-reviewed CAM academic journals (for example *Complementary Therapies in Medicine, the Journal of Alternative and Complementary Medicine,* or *Complementary Medicine in Nursing and Midwifery*). Several research centres in British universities are CAM research units rather than research centres for individual CAM therapies. Examples are the CAM Research Group at the University of Southampton, the Complementary Medicine Research Group at Peninsula Medical School, and Birmingham University Research Network for Complementary and Alternative Medicine.

The popularity of CAM and the report of the House of Lords Select Committee

The popularity of CAM is growing both in the UK and worldwide (Bodeker and Burford, 2007, p. 9; Ong et al., 2005; Ong and Banks, 2003) and as a result it can no longer be considered as 'peripheral' or 'fringe' (Cant and Sharma, 1999, p.3). In their review of CAM utilisation and its status in the UK, Ong et al. argue that

> The United Kingdom of Great Britain and Northern Ireland represents the face of modern health care in an industrialised European country. Pluralism is becoming a norm, with consumers voting, with both feet and wallets, for the type of health care that they want and expect (Ong et al., 2005, p. 143).

According to data obtained from a health survey in England (Hunt et al., 2010), 26 percent of the population used CAM during the year 2005, and a 44 percent used CAM at least once in their life. Women, university educated respondents, those suffering from anxiety or depression, and those with lower perceived social support, were more likely to use CAM. Thomas and Coleman's commonly-cited survey (Thomas and Coleman, 2004) estimated that 10 percent of the GB population saw a CAM practitioner during the year 2001, with the most visited therapies being massage, homeopathy, osteopathy, acupuncture, chiropractic and

reflexology. According to the survey 1.9 percent of the British population received homeopathic treatment from a practitioner in the past 12 months (Thomas and Coleman, 2004, p. 154). In 2005 the proportion of the population in England who used acupuncture at one point in their life ('lifetime users') was 11.2 percent (Hunt et al, 2010).

Strong correlations between the use of CAM and gross socio-economic indicators are demonstrated in the survey. For example there was a significant positive association between CAM usage and people from non-manual occupations, those who stayed longer in full-time education, and those with a gross income of over £15,600. Seventy-nine percent of CAM is paid for by patients out of their own pocket, which comes to approximately £13.62 per month per person. According to Thomas and Coleman's survey, during 2001 the NHS accounted for around 10 percent of all CAM consultations in England at an estimated cost of £50-55 million. A 2001 survey estimated that the proportion of general practices offering any CAM provision or referral has grown from 40 percent in 1995 to near 50 percent in 2001 (Thomas, Coleman and Nicolle, 2003). According to this survey, acupuncture and homeopathy are the two CAM therapies provided/referred to most. Similar trends are shown in international surveys. For example it is estimated that around 38 percent of the US adult population is using some form of CAM (National Center for Complementary and Alternative Medicine, 2008) while in Australia, the overall use of CAM is 52 percent, with 23 percent visiting an alternative practitioner at least once (MacLennan, Wilson and Taylor, 2003). In South Korea, 75 percent of the general population used CAM during 2006, including the consumption of herbal and dietary supplements (Ock et al, 2009). The two most popular CAM in high-income countries[8] are homeopathy and acupuncture, both exceeded in low-income countries[9] only by the use of herbal/traditional remedies (Ong et al., 2005, p. 63).

In light of CAM' s increasing popularity and issues of public health policy deriving from it such as the safety and efficacy of the therapies, a House of Lords Select Committee published a report in which significant recommendations in relation to

[8] GDP=Int$ 15,000
[9] GDP<Int$ 15,000

CAM in the UK were made (House of Lords Select Committee, 2000). The report explored concerns with the lack of regulatory structures in most CAM and the fact that, aside from chiropractic and osteopathy, all CAM practitioners were allowed to practise without training, without indemnity insurance and without affiliation to a registered body (Hunt, 2009). The report also expressed concern with the lack of scientific medical evidence for CAM. It called for the generation of clinical evidence over therapies' efficacy and safety, for increasing the availability of CAM information resources, and for the development of research training for CAM practitioners. The report highlighted the diverse standards and 'unacceptable' fragmentation within much of CAM, calling for improved regulatory structures for several therapies. Such steps, the report argued, are necessary to ensure standardisation of training, facilitation and removal of unsafe practitioners, while guaranteeing that practitioners work within their competencies (ibid). Amongst the report's concrete recommendations was a call for partnership between what the report described as 'properly regulated CAM professions' and Higher Educational Institutions (HEI) to ensure that CAM practitioners are well trained:

> CAM training courses vary unacceptably in content, depth and duration. Only a concerted partnership between higher educational institutions and properly regulated professions as validating bodies will adequately ensure that any CAM practitioner is well trained. Accredited training of CAM practitioners is vital in ensuring that the public are protected from incompetent practitioners (House of Lords Select Committee, 2000, summary).

This recommendation, as I shall discuss in Chapter Three, is central to the professional development and professional future of NMQ acupuncturists and homeopaths in the UK. In the following section I will provide a short historical description of the emergence of CAM alongside its relationship with conventional medicine. Such a description is essential to the understanding of CAM's holistic discourse and to the development of a sociological perspective over CAM practice.

1.5 The historical context of CAM: its emergence, decline, and re-emergence

Turner (2004) argues that in order to understand the challenges and questions CAM brings with it to the sociology of health and illness, it is important to examine its historical development alongside biomedicine. This includes the development of biomedicine and its rise to societal dominance; the decline and then the revival of CAM as part of the medical counter-culture; and efforts of CAM therapies to move closer to the mainstream. Frohock (2002) too suggests that the identities of all versions of CAM depend on the existence of conventional medicine, and that the relationship between CAM and conventional medicine is based on variables of time, place, and the attitude of healthcare practitioners. Indeed, as argued by Saks (2003a), 'alternative' medicine is a relative definition: what used to be the orthodoxy of one age could turn 'alternative' in another, and vice versa.

The biomedical model started dominating formal medical care in the West at the end of the 18th century (Nettleton, 1995, p.3). The term 'biomedicine' relates to 'biology' and 'medicine', and the model was founded upon scientific techniques of objective observations of the patient (Lupton, 2006, p.90). Prior to the emergence of biomedicine, medical practice in the West was rooted in 5th century BC, based on texts and traditions from the Hippocratic corpus and those of his follower Galen, 600 years later (Bates, 2002). Arabic medical texts written between 900 and 1200 AC provided medieval Europe with the knowledge from which modern medicine eventually arose (Savage-Smith, 1997, p.40). This knowledge of how the body works was challenged by the scientific revolution during the 17th century, and by the philosophical developments that emerged during the Enlightenment Era in 17th and 18th centuries. Amongst the ideals developed during the Enlightenment Era, and rooted in rational thinking, was the belief in the power of reason in shaping human understanding of the world, assisted by developments in science and technology (Risse, 1992 cited in Lupton, 2006, p. 88).

During this period three important developments changed the face of medical knowledge (Cook, 1997). The first was the development of medical theory and practice based on the need to understand the chemistry and the material structure

of the body. This view and emerging knowledge-base led to the development of more precise ideas about the causes of illnesses while confronting well-established views that had existed for hundreds of years. The second important development was the significant increase in formally educated, certified medical practitioners. The third development was the sudden growth of the European population and with it the process of urbanisation, leading to poor and crowded living conditions. Governments had to intervene in order to address the deterioration in populations' health, an area that was previously mainly a private concern, which resulted in an increased allegiance between governments and the medical profession.

The rise to power of the medical profession

Despite the significant change in the perception of health and healing and the incorporation of rational thinking during the Enlightenment Era, it took time before the professional status of physicians and surgeons changed and until the medical establishment gained its powerful position and prestige (Wear, 1989, cited by Bates, 2002, p.13). Even in the 18th century most people still treated themselves (Lupton, 2006, p. 88). During this time it was difficult to distinguish between the different health care groups. For example, until the late 17th century elite members of the Royal College of Physicians believed in astrology (Wright, 1992 in Saks, 2003a). However, the development of scientific, increasingly organised medical knowledge, the increasing force of well-educated medically trained practitioners, and the major demographic changes in Britain and in Europe, laid the foundation for a dramatic political change in medical practice. Together with increasing control over registration, medical practice improved. Better recovery rates of patients led to an increase in the status of the medical profession (Lupton, 2006, p.89).

The Medical Registration Act in 1858 in Britain created a national medical monopoly that provided orthodox doctors with a protected title and self government of standards and education, with a single register that is controlled by doctors themselves (Saks, 2003a). It created a legal basis for the development of

a more unified theoretical basis for the newly defined profession, based on biomedical principles (Saks, 2001). Alternative practitioners, who were those who found themselves outside the borders of the newly defined medical profession, could still practise under the Common Law but without being on the medical register. At the same time the medical profession used its privileged position to adopt a range of professional strategies to attack and marginalise CAM (Saks and Lee-Treweek, 2005, p. 82). After a period of significant proliferation of alternative therapies such as homeopathy and naturopathy during the 19th century, CAM's popularity dropped dramatically by the mid-20th century (Saks, 2003a, p. 143). Most striking is the case of homeopathy that from being hugely popular in the USA, Britain and Europe, fell to near extinction (Thomas, 2001, p. 102; Turner, 2004).

The re-emergence of CAM, and its holistic discourse

Sociological and historical accounts describe how, after a long period of marginalisation, CAM's popularity re-emerged in Britain and in the West from around the mid-to-late 1960s as part of a medical 'counter-culture' (Bivins, 2001; Crawford, 2006; Goldstein, 1999; Saks, 2003b). During that time, increasingly loud voices within sociology critiqued the view that science provides absolute social and moral truths (Lupton, 2006, p. 11). This critique expressed concern with biomedicine's lack of attention to the environment of patients, as well as with conventional medicine's adverse effects and high costs. At the same time, consumer scepticism was emerging, demanding professional accountability of medical staff, more responsiveness to the consumers' voice, and more 'natural' and 'holistic' medical approaches (Bivins, 2001, p. 11). This critique of biomedicine[10] focused on its reductionist and oppressive nature, whilst CAM therapies were often described as a holistic alternative (Bates, 2002; Scott, 1999; Rosenberg, 1998, p. 345). According to Goldstein (1999, p. 47) holism is the most commonly held premise amongst all CAM. He argues that:

[10] I will further discuss the critique of biomedicine and the role of CAM as part of the holistic health movement and the medical 'counter-culture' in the next chapter.

> Because holism directly contradicts the beliefs in dualism and reductionism that are central to biomedicine, it is holism, most fundamentally, that separates alternative medicine from the premises of the conventional biomedical model (Goldstein, 1999, p. 44).

Broadly speaking, holism is the belief that entities are greater than the sum of their parts, or in relation to medical practice, individuals must be seen in the totality of their lives (Goldstein, 1999, p. 44). However, this concept has many interpretations. Since holism represents the critique of biomedicine as reductionist, CAM practitioners developed a holistic discourse as part of their rhetorical strategy for gaining popularity (Keshet, 2011, p. 504). In the next chapter I will return to this holistic discourse and I will examine its roots, its meanings, and its central place in CAM theory and practice.

As noted by Wiese, Oster and Pincombe (2010, p.335), while CAM is often discussed as one group, within the sociology of CAM there is a call for more understanding of individual therapies and a consideration of the differences between them. In this research I focus on the two most popular CAM in high-income countries, acupuncture and homeopathy (Ong et al., 2005, p. 63), two CAM that despite their global popularity emerged from very different historical and geographical roots. Acupuncture developed over at least two thousand years in the Far East as part of Chinese medicine (Argil, 2006, p. 378), while homeopathy developed in Europe around 250 years ago, parallel to the emergence of biomedicine (Bellavite, Conforti, Piasere and Ortolani, 2005, p. 445). Other than popularity, the two therapies share several characteristics.

As we shall see, acupuncture and homeopathy are both founded on theories and principles of practice which appear contradictory with, or at least very different to, that of biomedicine (Fulder, 1996). Moreover, both therapies can be described as ‘inherently holistic’, representing the reductionist critique of biomedicine (Goldstein, 1999). Although directed more at homeopathy, both therapies are under continuous attack on the basis of their ‘unscientific’, ‘implausible’ nature from parts of the medical establishment (Anekwe, 2010), parts of the media (e.g. *Alternative therapy degree attack*, 2007; Boseley, 2009; Goldacre, 2007; Hensher,

2010; Robbins, 2010; Sample, 2009; Sample 2010; The Sun Online, 2009), and by sections of academia (Giles, 2007; Colquhoun, 2007; Corbyn, 2008). Yet, both therapies have managed to a certain degree to penetrate the NHS. There are four homeopathic NHS hospitals and according to one survey conducted in 2001 (Thomas, Coleman and Nicholls, 2003), 33 percent of GP practices in England offer access to acupuncture and 21 percent to homeopathy.

Both acupuncture and homeopathy, like other CAM therapies, participate in efforts to move closer to the mainstream and increase their societal status through professional projects, which include the transition from informal to formal educational structures (Cant, 1996; Saks, 2005a; Saks and Lee-Treweek, 2005). Hence, acupuncture and homeopathy share several characteristics as well as some common challenges which provide an opportunity to learn from the way that each therapy, with its unique organisation and professional culture - including professional bodies, schools, and practitioners - negotiates these challenges. I will now turn to the description of acupuncture.

1.6 Acupuncture

Acupuncture is one of the main therapeutic approaches used in Chinese medicine, the others being Chinese herbal medicine, *tui na*[11], bleeding and cupping[12], *Qigong*[13], and dietetics (Argil, 2006). Acupuncture involves the insertion of hair thin needles into various points in the body. According to traditional acupuncturists, the underlying principle of treatment is that illness occurs when the body's *qi*, or vital energy, cannot flow freely. This flow can be disturbed for many reasons, for example emotional and physical stress, poor nutrition, infection or injury (British Acupuncture Council, n.d.). The aim of the acupuncturist is to use needling to re-establish the free flow of *qi*. Needles are

[11] *Tui Na*, literally 'pushing and pulling' refers to a system of massage, manual acupuncture points' stimulation, guided by Chinese medicine principles (Argil, 2006).
[12] Cupping and bleeding can be used separately or often alongside other therapeutic approaches in Chinese medicine. Cupping involves inducing a vacuum in a small glass and promptly applying it to the skin (Argil, 2006).
[13] Manipulation of *'qi'* by means of exercise, breathing, and influence of the mind (Argil, 2006).

inserted in acupuncture points ('acupoints') along the 'meridians', which are the channels where the *qi* is assumed to be flowing (VanderPloeg and Yi, 2009, p. 26). Needling in acupuncture is often accompanied by the application of 'moxibustion', which is the heating of acupuncture points using the herb Artemisia vulgaris. Once needles are inserted, they are manipulated with or without moxibustion, although nowadays needles may also be manipulated using various other methods such as electrical stimulation (electro-acupuncture) or laser energy (ibid).

In light of its ancient history, it is not surprising that acupuncture has many different interpretations and styles of practice (Birch, 1998). Broadly speaking, the two main approaches practised in the UK are 'traditional acupuncture' and 'Western medical acupuncture', although, as demonstrated by Birch (1998), there is a diversity of traditional explanatory models in practice. While traditional acupuncture is grounded in the ancient philosophy of Chinese medicine, in contrast, Western acupuncture borrowed this ancient technique but undressed it from its philosophical roots and adapted it according to a biomedical explanatory model (White, 2009).

Tracing the exact origins and history of acupuncture is a complex operation. The mythical roots of Chinese medicine are linked to three legendary Chinese emperors who date from nearly 5,000 years ago (Argil, 2006, p. 378). However, it is generally agreed that the basics of Chinese medicine as a medical system were first gathered in the *Yellow Emperor's Inner Classic.* This text was compiled around 200 BC and was probably based on data gathered over many centuries (ibid). Acupuncture emerged in Britain during the 18th century and peaked at the beginning of the 19th century (Bivins, 2001; Ramey and Buell, 2004). Like other CAM, it was then marginalised by the medical profession when it was established in the 1858, and by the mid-20th century it declined to near zero practice (Saks, 2005b). It was only during President Nixon's visit to China in 1972 that the wider public of the West was exposed to acupuncture and the popularity of the therapy was accelerated (VanderPloeg and Yi, 2009, p. 27). Even before Nixon's visit reports on the 'sensational' Chinese medicine arrived in Britain and the US. These

were followed by visits to China by American and British surgeons who were amazed to witness acupuncture-assisted surgery without the use of anaesthetics (Bivins, 2001). However, the enthusiasm for the 'exciting oriental medicine' should also be seen in the broader societal context as part of the medical counter-culture which emerged from the mid-1960s.

Western medical acupuncture

When Mao's China opened to the West and acupuncture received significant public attention in the UK, aside from sporadic support, the general attitude of the medical profession towards this treatment can be described as sceptical to hostile (Bivins, 2001, p. 12). This unenthusiastic approach prompted conventional doctors who used acupuncture to seek scientific explanations for its effectiveness. By that they hoped to increase its status amongst medics, creating the 'science of acupuncture' which resulted in what is known as 'medical' or 'Western' acupuncture. While Western medical acupuncture has evolved from Chinese acupuncture, its practitioners no longer adhere to fundamental Chinese medicine concepts such as *yin/yang* and circulation of *qi* in the meridians. Instead, they explain acupuncture in biomedical terms, arguing that the acupuncture needles act mainly by stimulating various functions of the nervous system (White, 2009). According to Saks (2005b, p. 256), medical acupuncture tends to favour a limited version of acupuncture in relation to three areas: restricting scope of practice to areas such as pain and addictions; a 'symptomatic' formulaic approach of matching acupuncture points to conditions rather than seeing the patients holistically; and the biomedical, neurophysiologic explanation of acupuncture's mechanism of action. In doing so, Western acupuncture has abandoned much of the holistic premise of acupuncture such as treating patients with their individual, unique make-up and considering the inter-connectedness between body, mind and spirit. Western medical acupuncture is principally practised by conventional health care practitioners such as conventional doctors and physiotherapists, and is mainly used to treat musculoskeletal pain. While some Western medical acupuncturists reject the theory of traditional acupuncture (Ulett, Han and Han,

1998), others call for mutual appreciation of both approaches (VanderPloeg and Yi, 2009).

Acupuncture practice in the UK: practitioners, training, professional bodies and NHS provision

According to the European Traditional Chinese Medicine Association[14] (2010) there are around 10-12,000 acupuncturists in the UK, about 4,000 of whom practise traditional acupuncture. There are also around 4,500 physiotherapists[15] and 2,500 medical doctors who predominantly practise Western medical acupuncture as an adjunct to their primary therapy. As evident in surveys of CAM consumption earlier described in this chapter, the majority of acupuncture practice is in the private market, although there is significant provision of acupuncture within the NHS. It should be noted that according to a study by the British Medical Association (2000, in Saks, 2005a) the majority of acupuncture provision in the NHS is of Western medical acupuncture rather than traditional acupuncture.

The UK has currently no statutory regulation of acupuncture. Biomedical professionals, however, such as registered medical practitioners and physiotherapists who practise acupuncture as part of their practice, are subject to such regulation (Bishop, Zaman and Lewith, 2011). In statutory regulation, the title of the registered therapy is protected. Practitioners, by law, have to join the register of the regulatory body otherwise it would be unlawful for them to practise. Within CAM, statutory regulation has already been achieved for osteopathy and chiropractic (House of Lords Select Committee, 2000). The largest professional body of traditional acupuncturists is the British Acupuncture Council (BAcC) (British Acupuncture Council, 2009b). The BAcC represents around 2650

[14] An umbrella organisation for professional associations that represent different fields within Traditional Chinese Medicine (TCM) with the main purpose being to promote the wider recognition and acceptance of TCM therapies by European governments and the public (European Traditional Chinese Medicine Association, 2010).

[15] According to the AACP (2011) website, there are more than 6,000 physiotherapists who use acupuncture as part of their practice.

members who have qualified from a three-year full-time course, or the part-time equivalent of a course that was approved by the council (European Traditional Chinese Medicine Association, 2010). Since the mid-1990s, many of the courses are taught as BSc either by universities, or in private schools that are validated by a university (Isbell, 2004).

The British Medical Acupuncture Society (BMAS) represents around 2700 doctors and allied health professionals who practise medical (Western) acupuncture (British Medical Acupuncture Society, n.d.). Membership of the BMAS is open to most UK-based health professionals who are subject to statutory regulation, including doctors, dentists, physiotherapists, nurses, midwives, health visitors, osteopaths, chiropractors, and podiatrists. The basic BMAS acupuncture training is significantly shorter than that of traditional acupuncturists. BMAS accreditation and diploma in medical acupuncture (Dip. Med. Ac.) is available to those who have achieved a minimum of 100 'training hours', normally achieved by a combination of participation in courses, attendance at meetings and by distance learning (British Medical Acupuncture Society, 2011).

Another major professional body is the Acupuncture Association of Chartered Physiotherapists (AACP) (Acupuncture Association of Chartered Physiotherapists, 2010). During my research I witnessed the way acupuncture is naturally integrated into day-to-day practice in several NHS physiotherapy centres as part of the practitioners' therapeutic arsenal. The basic acupuncture training on AACP courses is 80 hours long. Although most traditional acupuncturists are members of the BAcC, it is possible to find medically trained acupuncturists who use the traditional rather than the Western approach and choose to be members of the BAcC (Bishop, Zaman and Lewith, 2011, p. 145). I will now turn to describe the second therapy at the centre of this research, homeopathy.

1.7 Homeopathy

Homeopathy was developed in Germany by Samuel Hahnemann (1755-1843) from the 1790's onwards as a distinct system of medicine. Although Hahnemann was a well established chemist, pharmacologist and physician, he is mainly known as the founder of homeopathy (Bellavite et al., 2005, p. 445). In a series of experiments and observations, Hahnemann developed homeopathy as a gentle alternative to the aggressive medical treatment of the time (Nicholls, Lee-Treweek & Heller, 2005). 'Homeos' means 'like' or 'similar' in Greek and 'pathos' means 'suffering', which points to the underlying principle of the therapy and its main source of controversy, which is 'the law of similars' or 'like cures like'. According to this principle, a substance taken in very small amounts will cure the same symptoms it would cause if it was taken in large amounts (Faculty of Homeopathy, 2010; Lange, 2005, p. 387). In fact, in homeopathy, remedies are often being diluted to such a degree that in many cases they contain no detectable trace of the original substance (Chapman, 1999). The principle of 'like cures like' is often employed by scientists and conventional doctors to attack homeopathy. For example, professor Edzard Ernst, who was the head of the department of Complementary Medicine at the University of Exeter, argues that homeopathic principles stand in contrast to what we know about the laws of nature:

> There are, of course, many therapies of which we currently do not understand how they work. But homeopathy is different: we do understand that it cannot work, unless we re-write whole chapters in basic textbooks of science (Ernst, 2007, p. 280).

In contrast to this view, some homeopaths suggest that while preparing homeopathic remedies, in the process of diluting and shaking[16], the water used is able to store and carry the 'memory' of the original substance in a mechanism that is yet to be demonstrated (British Homeopathic Association, 2010). Another central homeopathic concept is the 'vital force' and the body's assumed tendency to heal itself through the 'healing power of nature' (Carlston, 2006, p. 97; Nicholls

[16] 'Succussion' is the homeopathic terminology for the way remedies are shaken between dilutions in the process of remedy preparation (British Homeopathic Association, n.d.)

et al., 2005, p. 105). The vital force is provoked in homeopathy by the homeopathic remedy[17] which is matched with the person's unique presentation of symptoms. It should be noted that homeopaths do not regard the symptoms as the disease but rather an expression of the body's reaction to an underlying problem (Fulder, 1996, p. 201), and in practice they are looking for the suitable remedy that would stimulate the body's own healing forces.

The process of matching a remedy to the patient requires careful attention to personal, often intimate biographic details, and is a time-consuming process. A typical homeopathic consultation can take anywhere between 30 and 90 minutes, depending on the case and on the practitioner's style of practice. During this homeopathic interview, the homeopath collects detailed information about the patient's current illness, as well as about other aspects of the patient's life, may it be physical, sensory, emotional, mental or even moral (ibid, p. 202). This process requires the homeopath to explore the unique expression of symptoms in the individual patient. In principle, each patient suffering say migraine attacks, will have a slightly different presentation of symptoms (e.g. the patient suffers migraines mostly on weekends, usually starting at noon, is relieved when opening the window to a light breeze, symptoms worsen when standing up etc.). The homeopath then has to match these symptoms to a suitable homeopathic remedy. There are more than 2000 remedies which are described in detail in the 'materia medica', the book of homeopathic remedies (Jacobs and Moskowitz, 2001, p. 89). There are, however, different material medica which have been introduced by various influential homeopaths with each version providing slightly different descriptions of remedies. Different schools and different homeopaths use different materia medica according to their style of practice.

[17] Remedy is the term used by the homeopath to refer to the medicine used in each individual case. The remedies are made of many different substances such as herb-parts, metals, minerals, animal products, disease products etc (Jacobs and Moskowitz, 2001).

The origins of homeopathy and its fluctuating popularity

Homeopathy has experienced several ups and downs in popularity throughout its history. It saw a rapid boom in many parts of the world during the 19th century, including most European countries, the US, Cuba, Mexico, Russia, India and South America. This was likely due to the fact that other forms of medicine of the time where aggressive and painful, and due to the reputation of homeopathy in treating the epidemics that swept through Europe and America in the 1800's, such as typhoid, cholera and yellow fever (Bellavite et al., 2005, p. 447; Lange, 2005, p. 388; Thomas, 2001, p. 101). Homeopathy started appearing in the UK in the 1830s, and championed by Hervey Quin, a popular doctor with strong links to the social elite, it became fashionable and gained high public profile (Nicholls et al., 2005). In 1843 Quin founded the British Medical Homeopathic Society and in 1849 he established the first London Homeopathic Hospital (Nicholls, 2005, p. 204). An example of the popularity of homeopathy in the 18th century is the way it flourished in the US. During the 18th century, homeopathy was taught at main American universities with as many as 29 homeopathic journals being published (Bellavite et al., 2005, p. 449). In 1844 the American Institute of Homeopathy was founded as the first American National Medical Institute. By 1892 there were 110 homeopathic hospitals and 145 dispensaries in the United States (Lange, 2005, p. 388) and more than 9,000 homeopaths, constituting eight percent of all medical professionals in that country (Kirschmann, 2003, pp. 7).

The increasing popularity of homeopathy, and moreover its popularity among the social elite in the UK, Europe and the US, led to clashes with the medical profession as homeopathy was perceived as a threat to their profit and as unwanted competition (Bellavite et al., 2005, p. 447; Nicholls et al, 2005, p. 102; Thomas, 2001, p. 100). With the fast development of biomedicine, which by the second half of the 19th century had gradually abandoned the aggressive practices of heroic medicine (Kirschmann, 2003, p. 21; Nicholls et al., 2005, p.112), the tension between biomedicine and homeopathy grew. Many homeopaths claimed that biomedical doctors use aggressive drugs which were toxic and which suppress symptoms rather than promote healing. During the same period, with the growing alliance between the medical profession and the state, bitter attacks

on homeopathy were launched by the medical profession in both the UK and the US (Nicholls, 1988 in Cant & Sharma, 1999, p. 87).

Right from its establishment in 1847, the American Medical Association pursued policies hostile to homeopathy in an attempt to combat the popularity of homeopathy. This was a move that was based on the aforementioned threat of unwanted competition as well as on homeopathy's perceived lack of scientific evidence. Doctors were not allowed to practise homeopathy, to consult with a homeopath, or support a patient who chose to be treated by a homeopath (Bellavite et al., 2005, p. 449; Thomas, 2001, p. 100). Following the 1910 Flexner report[18], which defined the excellence of American medical schools with an emphasis on teaching pathology and biochemistry, homeopathic colleges were poorly rated. Their popularity dropped and within ten years only four homeopathic medical colleges remained (Thomas, 2001, p. 102; Turner, 2004). By 1950 there were no homeopathic colleges left in the US and it was estimated that only about one hundred practicing homeopaths remained in practice.

As in the US, and for the same reasons mentioned earlier, the popularity and the status of homeopathy in the UK dwindled. In reviewing homeopathic medical dictionaries in the UK, Morell (1998) demonstrates how between 1876 and 1930, the number of homeopathic dispensaries in the country dropped from 120 to 29. Nevertheless, homeopathy was officially made part of the NHS at its inception in 1848. In reviewing the development of homeopathy in the UK, Nicholls (2005) suggests that its NHS inclusion is a result of several factors: a concentrated and uncharacteristically unified effort by both the British Homeopathic Society (the medically trained homeopaths) and the British Homeopathic Association (non-medically trained homeopaths), and support for homeopathy by the Royal family. Morell (1998) argues that as a result of the upper-class patronage of homeopathy, it 'could never shake off its aristocratic gloss' and appeal to the 'lower' classes. This support, which was at first a great benefit, turned into an obstacle to homeopaths' societal status.

[18] The Flexner report (1910) followed on from a survey of American medical schools initiated by the American Medical Association in 1904. The report criticised medical education in the US including sharp criticism of the homeopathic medical colleges, and led to significant reforms in American medical education (Thomas, 2001, p. 102).

Like acupuncture, homeopathy in the UK is practiced by both medically qualified and non-medically qualified practitioners. Homeopathy too experienced division in practice between the two practitioners groups. In the next section I will describe the division within homeopathy between the two groups, which demonstrates the relationships between expert knowledge and the societal status of practice, an issue that will be discussed later in this thesis.

The division between 'classical' and 'medical' homeopaths

Another factor that contributed to the downfall of homeopathy between 1880 and 1950 was the impact of philosophical debates and in-fighting within homeopathy. The debate was between the 'purists', who followed Hahnemann as the ultimate authority, and practitioners who tried to further develop homeopathic principles and theory, including practitioners who wanted to align homeopathy with biomedicine (Kirschmann, 2003). According to Thomas (2001, p. 101), by 1870 most homeopaths abandoned the strict original Hahnemannian principles, which required spending a very long time with the patient in an attempt to elicit the most personalised constitutional remedy. In practice the classical approach requires the homeopath to elicit detailed information about the individual patient's life, including on physiological, mental and emotional levels. Instead, non-classical homeopaths started prescribing more according to a relatively brief pathological diagnosis, much like in orthodox medicine, paying more attention to the mere physiological symptoms of the patient. This division in practice, which is still ongoing today, led to the establishment of two separate professional bodies. Quinn established the British Homeopathic Society (BHS) in 1843, representing medical doctors practising homeopathy. In 1944 the BHS became the Faculty of Homeopathy (FoH). In 1978 a group of non-medically homeopaths established the Society of Homeopaths (SoH), the largest professional body representing classical homeopaths in the UK (Nicholls et al., 2005, p. 114).

The revival of homeopathy and its current status in the UK

Like other CAM, homeopathy too was revived as part of the medical counter-culture. Globally, according to the WHO, homeopathy has approximately 300 million users, making it the most popular CAM in high income countries (Nicholls et al., 2005, p. 102; Ong et al., 2005; Saks, 2003a, p. 143). The UK is the only country in the European Union with public-sector CAM hospitals (Ong, Bodeker & Burford, 2005, p.145). NHS homeopathic hospitals operate in Bristol, London, Liverpool, and Glasgow (and until several years ago also in Tunbridge Wells). The Royal London Hospital for Integrated Medicine (formerly known as the Royal London Homeopathic Hospital) holds 27,000 NHS patient appointments a year (Faculty of Homeopathy, 2011). There are around 400 GPs practising homeopathy, treating around 200,000 NHS patients per year with homeopathy (ibid).

Currently, there is no single body regulating NMQ homeopaths. Rather, UK homeopathic practitioners belong to several professional bodies, which are struggling to agree on the future of the homeopathy profession. In effect, practitioners are not required by law to be members of a professional organisation or to complete any specific training (Prince of Wales's Foundation for Integrated Health, 2008). The Society of Homeopaths (SoH) is the largest professional body of NMQ practitioners, representing 1300 members who are trained in classical homeopathy (Society of Homeopaths, 2011a). As for medically qualified homeopaths, the Faculty of Homeopathy (FoH) represents over 1400 members who are all statutorily registered conventional healthcare professionals, including doctors, nurses, dentists and pharmacists, (Faculty of Homeopathy, 2011). As in acupuncture, it is possible to find medically trained practitioners practising classical homeopathy, and classically trained practitioners who practise complex homeopathy[19] and other non-classical approaches. Barry (2006, p. 90) suggests that homeopathy practice in the UK offers several 'layers of plurality'. In training

[19] While 'purist' classical homeopaths prescribe in chronic cases only one 'most suitable' remedy to the individual patient, there are several other approaches to homeopathic prescribing. One approach, commonly used by the non-classical practitioners, is to combine several remedies that work together. Usually this approach is more pragmatic and physiological-oriented in nature and less 'emotionally profound'.

there are both ‘medical’ and ‘lay’ homeopathy courses while in practice there are the classical as well as the ‘medicalised’ approaches. Moreover, in relation to the setting of practice, homeopathy can be found mostly in the private market but also on the NHS.

In this introductory chapter, I have set the scene for the research by providing background information about the field of inquiry. Before moving to the next chapter to explore the conceptual threads leading the research, I will provide a brief description of the thesis’ structure.

1.8 Thesis structure

This chapter has introduced the thesis and set the scene of my research. It has presented the research, its aim, the research questions, background information describing the CAM ‘scene’, and the two therapies being researched, acupuncture and homeopathy. *Chapter Two* is a review of the literature and conceptualisation of two perspectives over ‘holism’. The first is the critique of biomedicine as ‘reductionist’, ‘dualistic’ and ‘oppressive’, and with it the re-emergence of CAM as ‘holistic’. The second critique is that of CAM’s holistic discourse, highlighting potential tensions within this discourse. *Chapter Three* is a review of the literature and conceptualisation of the relationship between acupuncture and homeopathy’s holistic discourse and the therapies efforts to formalise their educational structures. In this chapter I briefly discuss professionalisation and strategies of social closure, the efforts to professionalise CAM in that context, and with it formalising acupuncture and homeopathy education. I then consider the nature of expert knowledge, and the ratio between the ‘technical’, standard-bound which is increased in the process of regulation and standardisation of professional knowledge, and the ‘indeterminate’, un-codified, intuitive, experience-driven elements of expert knowledge. The perspective of closure strategies and the levels of technical/indeterminate knowledge are important in understanding some of the challenges that are part of formalising CAM education. *Chapter Four* evaluates the epistemological approach and the methodological considerations undertaken in this investigation. This includes a discussion of methods of data

collection, data analysis, and ethical considerations. *Chapter Five* examines the data in relation the holistic discourse of NMQ acupuncturists and homeopaths, their professional bodies, and their schools, and the meanings that they attach to holism. The chapter considers practitioners' reflectivity and awareness of potential limitations and potential tensions in CAM's holistic claims. *Chapters Six* and *Seven* explore the challenges that are part of formalising the therapies' educational structures, including HEI involvement in that process. These chapters consider the impact of formalising education on the therapies' holistic discourse in relation to acupuncture and Chapter Seven in relation to homeopathy. Finally, *Chapter Eight* is a concluding Chapter, pulling together the main findings of this investigation along the conceptual threads guiding the research. In this chapter I will discuss contributions to theory and to methodology, including the limitations of my research. I will look at contributions to acupuncture and homeopathy training and practice, and I will offer suggestions for potential future research.

Chapter 2

The holistic discourse in CAM

The aim of the chapter is to conceptualise the various holistic concepts that are part of CAM's holistic discourse. In order to do that, I would argue that there is a need to contextualise this discourse alongside the critique of biomedicine, a critique which is interwoven in CAM's holistic discourse. Just as tracing the emergence of CAM requires a description of the emergence of biomedicine (Frohock, 2002; Saks, 2003a), so does a consideration of CAM's holistic outlook require a discussion of the critique of biomedicine.

It is important at this point, to clarify a couple of points in relation to this thesis. First, while reviewing certain sociological concepts I would like to point out that this is not a 'purely sociological' thesis. Rather, sociology has been a helpful theoretical perspective to guide the examination and conceptualisation of holism and the processes of formalising acupuncture and homeopathy education. Moreover, while providing the following brief overview of the critique of biomedicine, I recognise the complexities behind the various perspectives and concepts that are described. Such overview provides the broad context for the emergence of CAM and its holistic discourse.

Second, as part of the discussion of CAM's holistic discourse, I would like to clarify the rather unavoidable stereotypical nature of parts of the discussion. While it is helpful to explore this holistic discourse in relation to the critique of biomedicine, it is definitely not my intention to argue that biomedicine is purely reductionist or 'un-holistic' in nature or that CAM is exactly the opposite. On the contrary, in this chapter I will mention holistic discussions in biomedicine and I will highlight some tensions in the holistic discourse of CAM. The complex nature of such a comparative discussion is captured by Bates (2002), who used a historical perspective to compare and contrast the evolving characteristics of biomedicine and of alternative medicine over time:

> For that reason, I regard the following lists of characteristics of the two paradigms as largely stereotypes, caricatures, or superficial depictions of thinking and talking about health and disease over time. Indeed, given the remarkable complexities of the therapeutic act, such superficiality could hardly be avoided (Bates, 2002, p. 14).

Therefore, this chapter reviews the literature discussing, on the one hand, the roots of biomedicine's characterisation as 'reductionist', 'dualistic' and 'oppressive', and, on the other hand, the roots for CAM's description as holistic, or in other words, as anti-reductionist, anti-dualistic and anti-oppressive. At the same time, in the second part of this chapter, I will consider an emerging literature which highlights a number of tensions in CAM's holistic discourse. Exploring the meanings attached to holism by acupuncturists and homeopaths, and the role holism plays in the construction and transmission of these therapies' knowledge is a complicated endeavour. Holism is fluid and elusive, with multiple interpretations, or as in Rosenberg's words, it is an 'elusive yet indispensible' term (1998, p. 335). While most CAM modalities claim to be holistic, the concept is not always understood in the same way by the various practitioners (Cant & Sharma, 1999, p. 8; Stone & Katz, 2005, p. 219).

In order to understand the emergence of CAM's holistic discourse and of holism as a reflection of the critique of the biomedical model, I will first review this critique as part of the sociology of health and illness. I will discuss the concepts of 'professional power' and 'the construction of medical knowledge' which are central to this critique. This will be followed with a discussion of the re-emergence of CAM and its holistic discourse as part of a medical counter-culture, and therefore, as part of the critique of biomedicine. This holistic discourse is then examined in light of an emerging literature which highlighted several tensions in CAM's holistic claims.

2.1 The sociology of health and illness and the critique of biomedicine

To follow the sociological critique that emerged in relation to biomedicine requires an analysis of the main concerns of the sociology of health and illness. At the centre of the sociology of health is the argument that scientific knowledge is a social product and that medical knowledge in social terms is a product of specific societies. The functionalist view, of which Parsons was a major representative, was concerned with how individuals' aspirations and beliefs comply with the social order and society as a whole (Turner, 1995). Here, the ethical character of the professions is emphasised and professional groups are seen as necessary groups and as a stabilising force in a capitalist society, contributing to the order of society (Parsons, 1939). In line with this view, the medical profession, with its powerful position, is seen as a legitimate authority that is accepted by society in light of the benefits it brings to society as a whole (Hardey, 1998, p. 22). Such an idealistic presentation of the social role of professions as based on a disinterested commitment to community values did not challenge the way that health care was organised and delivered, or the way that medical knowledge is constructed and transmitted (Turner, 1995, p. 129). While the functionalist approach was groundbreaking in addressing the social dimension of the medical encounter (Lupton, 2006, p. 7), it was criticised for ignoring the conflicts and power-relations at the heart of the doctor-patient relationship, as well as for undermining the complex political motivation of the medical profession and the influence it has on society.

The political economy theory of professions, which developed in the 1970s and 1980s, grew as a critical response to functionalism (Lupton, 2006, p. 8). This approach took a critical view of the societal role of professions, including the medical profession. It highlights the way that political systems and the state shape power arrangements and inequalities in a society where social policy is a result of social struggles and conflicts (Giddens, 2006). It was Freidson's (1970) influential work that stressed the role of power in the medical division of labour. He noted that the power of medicine derived both from the profession's autonomy and its dominance in the health care division of labour, allowing it to subordinate related occupations Through their monopoly over medical practice physicians gained a

dominant position over the entire field of medical practice and were in a position to define what is considered a disease or how it should be treated:

> Thus, the medical profession has first claim to jurisdiction over the label of illness and anything to which it may be attached, irrespective of its capacity to deal with it effectively (Freidson, 1970, p. 251).

Freidson discussed the way that the medical profession exercises autonomy to prevent intervention and interference by 'outsiders'. Marxist authors adopted these perspectives on power to suggest that professional dominance is of particular importance in capitalist society. They argued that under state protection, professional bodies contribute to the economic system which determines the social structure in that society, and that the distribution of ownership of means of production is characterised by inequalities of power (Turner, 1995, p. 130). Political economists questioned the ethical character of the medical profession, arguing that medicine in a capitalist society represents the face of capitalism. The principles of altruism, service and ethical nature were seen from a different perspective, and as 'less than perfect human social constructs rather than as abstract standards which characterised a formal collectively' (Macdonald, 1995, p. 4).

Other critiques argue that although the medical profession requires a degree of autonomy and control as part of what its functions require, the medics' use of their power has gone too far. This can be seen in the way doctors influence, or are involved with, legal systems and employment, and in the way that the medical profession claims monopoly over medical knowledge; i.e. what should be considered as 'true' or 'beneficial'; how such data should be generated or examined; who should be able to practice, and what should be the degree of attentiveness to the patient's perspective (Lupton, 2006). Critics of the political economy approach suggest that it oversimplifies the powerful position of doctors and the medical profession in ignoring events that are taking place as part of the routine investigation of patient's illness. Such critics argue that representing the doctor-patient relationship as similar to a relationship in which a capitalist exploits

a worker ignores the fact that behind the societal processes there is a suffering individual, and that the doctor's basic wish is to help this patient (Gerhard, 1989 in Lupton, 2006, p. 11).

Another sociological approach to the sociology of health and illness is 'social constructionism' It argues that professions such as medicine and law are able to practice control and hold a powerful position in society because they are the ones determining what counts as knowledge in their particular field (Saks & Lee-Treweek, 2005). As discussed by Cant and Sharma (1999, p.11), biomedicine grew in power from its political alliance with the state in Western countries. This alliance has led to a biomedical hegemony which encompasses claims of knowledge and expertise. This hegemony allows the medical profession to gain control over political decision-making, and it provided biomedicine with the authority to define objectivity, rationality, and morality in medical practice. Social constructionists argued that medical knowledge is political 'rather than technically neutral enterprise' (Nettleton, 1995, p. 18). According to the social constructionist view, what is considered as 'truth' in certain areas, including notions of health and illness, is never neutral from the social context. Rather, it is produced in relation to one group's motivation and interest in the context of power relations between interested parties (Lupton, 2006, p. 11).

This discourse of medical knowledge as part of political and social circumstances is important in order to understand the forces which led to the medical counter culture and with it to CAM's holistic discourse. I will now continue to describe the emerging sociological critique of biomedicine as 'oppressive', 'dualistic' and 'reductionist', starting with the challenge of seeing science as the only 'true' way of knowing.

The critique of biomedicine as 'true' form of knowledge

As argued by Turner (1995, p. 18) much of the claims of medical expertise relies on knowledge of the disease. However, he stresses, such knowledge is socially constructed rather than objective. This brings about the question of the relativity of the construction of medical knowledge. As Turner highlight

> It is simply the case that different types of society have different types of disease and different approaches to therapy; these variations are the products of culture and social organisation (Turner, 1995, p. 18).

Turner highlights the process of secularisation of culture whereby religious beliefs lost their dominance as part of the growth of western rationality. This process corresponds with what he describes as intellectualisation of the mundane world, whereby science becomes the criteria for action. Within the medical sphere, the development of the medical institution and of medical surveillance represents components of the secularisation process. In that respect, the medical doctor replaced the priest in determining social values and the evolution of scientific medicine developed as a group of agencies of surveillance and control (ibid, p. 36).

Moreover, the rationalist view that science is said to provides a measure to assess what is 'real' and what is not, indifferent to culture and morals, has two major limitations, as recognised by Gelner (1979, p. 144): first, the scientific description of the world involves the loss of what Max Weber labelled as 'enchantment'. If the world is seen through an 'objective', as opposed to a 'subjective' lens, we lose the dimensions of mystery, imagination and faith. This presents us with a cold, insecure, disenchanted reality. Second, science does not help us in knowing how to organise our lives; how to resolve moral issues, or how to socially organise societies. It does not provide us with a sense of belonging to the world we live in, or the societies we inhabit. Sociologists of science suggest that scientific facts and biomedical knowledge are social processes and that their ideas are dependent on the scientific communities producing them (Nettleton, 1995, p. 21). One of the major philosophers of science, Thomas Kuhn, argued

that when a scientific field matures, with increasing numbers of scientists, courses and textbooks, members of the field adopt an ideological commitment to their profession which eventually creates a set of rules leading to a dogmatic framework (Kuhn, 1972, p.82). As a result, the knowledge produced during the interactions between the members of the profession is contextualised and is relative to these unique situations and to the sense-making of the event's participants.

Saks (1998) discussed the critique of biomedicine in the context of its rise in the modern world, and with it the rise of rational thought, as the process objectification and the depersonalisation of patients, resulting in a shift from a dialogical doctor-patient relationship to seeing the patient as a 'cluster of cells'. Moreover, this approach of medical practice maintained commitment to a single objective truth as far as medicine is concerned, rather than adopting a more postmodern perspective which tends to outline plurality of cultures, worldviews and social groups and willingness to combine multiple discourses (ibid, p. 204). According to Nettleton (1995) postmodernity involves abandoning the search for absolute truths based on scientific knowledge, and rather, acceptance of multiple realities and narratives.

The critique of biomedicine as 'reductionist', 'dualistic' and 'oppressive'

Nettleton (1995, p.3) describes the biomedical model as based on several assumptions: the body and mind can be treated in separation from one another; the body is seen as a machine which breaks down from time to time and while the doctor's role is to repair this dysfunction; and that medical practice relies heavily on technological interventions. In addition, biomedicine is reductionist in explaining the disease process, which means that it focuses on biological changes within the human body with little attention to social and psychological factors. This reductionist model is rooted in the doctrine of a specific aetiology which assumes that every disease is caused by a specific, identifiable agent, such as a bacteria or a virus. Critiques of the biomedical model pointed out that it is possible to become infected by a bacteria or a virus without developing an illness,

or that being part of a certain social group and living in a certain social environment may be at least as important a health determinant as the immediate contraction of germs and viruses (ibid, p. 5).

The Austrian philosopher Ivan Illich (1995, original work published in 1976) attacked the medical establishment over the harmful effects of medical interventions:

> The medical establishment has become a major threat to health. The disabling impact of professional control over medicine has reached the proportion of an epidemic. *Iatrogenesis*, the name for this new epidemic, comes from *iatros*, the Greek word for "physician", and *genesis*, meaning "origin". Discussions on the disease of medical progress has moved up on the agendas of medical conferences, researchers concentrates on the sick-making powers of diagnosis and therapy, and reports on paradoxical damage caused by cures for sickness takes up increasing space in the medical dope-sheets [emphases in original] (Illich, 1995, p.3).

Illich argued that the way that routine medical interventions are embedded in society leads people to a dependency on biomedicine, reducing their autonomy and ability to manage their own health in other ways available outside the medical establishment:

Zola (1972) discussed the term 'medicalisation' in reference to medicine as a powerful institution of social control. Medicalisation refers to the way that the medical profession claims an expert status over matters in life that were previously not regarded as medical concerns, for example, ageing or child birth. Zola argues that:

> ...medicine is becoming a major institution of social control, nudging aside, if not incorporating, the more traditional institutions of religion and law. It is becoming the new repository of truth, the place where absolute and often final judgements are made by supposedly morally neutral and objective experts. And these judgements are made, not in the name of virtue or legitimacy, but in the name of health. Moreover, this is not occurring through the political power physician hold or can influence, but is largely an

> insidious and often undramatic phenomenon accomplished by "medicalizing" much of daily living, by making medicine and the labels of "healthy" and "ill" *relevant* [emphasis in original] to an ever increasing part of human existence (Zola, 1972, p. 487).

The second wave feminist movement in the 1970s was influential in commenting on the oppressive nature of biomedicine and the way it differentiates between social groups and gender roles (Lupton, 2006, p.142). At the heart of this critique are medical and scientific justifications used in medical practice to discriminate women from men and prevent women from taking public roles. Extending the medicalisation thesis, feminist sociologists argue that the way that we are socialised into masculine and feminine roles will have an effect on our health and illness. Embedded in the feminist argument is the view that modern medicine helps shape such a division of social roles and that the main area of medical attention given to women is reproduction, which only underlines the role of women in society as child bearers and mothers. There are more women patients not because they are sicker, but as a result of the medicalisation of their life cycle. The doctor reinforces patriarchal values by regulating the sexuality of women and by supporting social roles and social arrangements in the family which are dominated by male control. What appears as a subtle 'neutral' doctor's advice to the patient is a form of real patriarchal management, characterising women as weak and dependent (Ehrenreich & English, 1978). In her discussion of homeopathy as a feminist form of medicine, Scott (1998) reviews work discussing the women's health movement which created a feminist discourse of resistance to biomedicine. She presents parallels between the development of feminist health activism and NMQ homeopathy practice. She argues that certain themes that have emerged as part of the critique of biomedicine by the second wave women's health movement, have also emerged within feminist homeopathy. For example she discusses homeopathy as addressing the power imbalance between the practitioner and the patient, and (while not necessarily put in practice) she suggests that homeopathic theory addresses social concerns which are often excluded from the biomedical model. Indeed, the preponderance of women in CAM on both sides of the therapeutic encounter is not surprising – for example, Scott points out that the vast majority of members of the SoH are women. Moreover, more women than men are likely to use CAM (Hunt et al., 2010).

According to Turner (2004), the medical profession's monopoly over health care in 'Western society' is challenged by a number of global processes. These include the growth of consumerism, transformations in the pattern of disease and the increase in chronic diseases, which require a long-term care model; rising health care costs; increased access to information through the Internet; and new health-related social movements which challenge biomedicine. In the figure below I summarise the key elements of the reductionist critique of biomedicine, which serves as a starting point for the discussion of holism in CAM.

Figure 1: A summary of the reductionist critique of biomedicine

2.2 CAM, holism and the medical counter-culture

It is at this point that the discussion of the emerging critique of biomedicine brings CAM into the picture. Since the late 1960s, the term 'counter-culture' has been used to describe groups who challenge certain aspects of mass industrial society (Goldstein, 1999, p.155). In the US, health played a central part in American culture and politics, with a growing public consciousness of lifestyle hazards, such as smoking, and of environmental concerns, and a desire to change 'risk' related behaviour (Crawford, 2006, p. 407). The growing epidemiological attention for environmental and lifestyle risks to health, contributed to the emergence of several health movements attentive to these concerns, including health promotion and the holistic health movement. Revelations of public controversies over additive and pesticides in food only contributed to an anti-corporate and anti-establishment environment (ibid).

At the same time, there was a growth in middle-class cultural practices of developing self-awareness and taking individual responsibility over health, that were well-placed in the growing health promotion movement (ibid, p. 409). These concerns overlapped with alternative medicine which emphasised the use of 'natural' approaches, personal responsibility over health, and altered states of consciousness (Goldstein, 1999, p.156). As Porter noted (2002), a renewed popularity in alternative medicine mirrored the counter-culture critique of biomedicine. By that time people were expecting much more from medicine and looked for explanations for their problems and for

> a sense of wholeness, a key to the problems of life, new feelings, of self-respect and control. If the tenor of orthodox medicine was pessimistic, alternative medicine instilled hope (Porter, 2002, p.51).

Indeed, in contrast to the description of biomedicine as 'narrow', and reductionist, CAM therapies conveyed the opposite with their holistic premise. Goldstein (1999, p. 47) argues that the most commonly held premise among all alternative medical systems is that of holism. According to Bates (2002) therapies that developed in the West in the late 18th century and in the early 19th century including

homeopathy, magnetic therapy, hydrotherapy, and later osteopathy, naturopathy and chiropractic, maintained many of the characteristics of the classical Hippo-Galenic tradition[20] (Bates, 2002) which asserts many of the aspects of holism. As discussed in the previous chapter, the establishment of the medical profession in effect placed the abovementioned therapies in a position of 'alternative medicine'. Since professionally and politically these alternative therapies sat outside biomedicine, and since many of the alternative therapies maintained some of the characteristics of the Hippo-Galenic tradition, they were well placed to convey the biomedical critique and join the medical counter-culture. It is perhaps these philosophical roots that naturally placed CAM as part of the medical counter-culture and which, as Rosenberg argues, is placing CAM therapies in a position in which they 'cumulatively illustrate the cultural tenacity and explanatory power of holistic ideas as well as their widespread cultural diffusion' (Rosenberg, 1998, p. 345). The holistic medical knowledge constructed and used as part of the CAM discourse contributed to its appeal. Indeed CAM practitioners use holistic claims as a rhetorical strategy for gaining popularity (Kehset, 2011, p. 504).

In the course of my research holism was very often mentioned. It is an integral part of the academic CAM literature; CAM textbooks; CAM practitioners' websites and practitioners' leaflets posted outside health food shops; professional bodies' websites, and CAM schools' information. In fact, it seems that in the few decades that followed the re-emergence of CAM a certain frustration developed in relation to the use, or - as some suggest - the overuse and even misuse of the term holism. Such frustration is well articulated by Patrick Pietroni who founded the first general practice to incorporate complementary medicine, based at Marylebone Road, London. In an article in the journal *Complementary Therapies in Nursing & Midwifery* he argued:

> My main contention is that the alternative and complementary therapies have hijacked the word holism and so misused it and abused it that it has lost its meaning. In so doing they have inhibited the debate regarding the conceptual, clinical, and practical levels of the health care so necessary

[20] The terms Hippo-Galenic medicine refers to Hippocrates and Galen and the medical tradition (Bates, 2002), mentioned here in the Introductiory Chapter, which followed their writings for centuries.

> today. Little if any serious dialogue or criticism is heard other than general attacks on orthodox medicine and wholesale misunderstanding of the value of the detailed reductive, analytic work so characteristic of modern science. I believe that for many complementary and alternative practitioners, holism has become a form of 'holyism' and an aberration in the same way as the image of the 'blinkered uncaring scientific doctor' is a poor example of applied reductionism (Pietroni, 1997, p. 9).

In the following section I will explore the emergence of holism in the context of medical practice in general and as part of CAM in particular, and the different meanings that are attached to holism.

2.3 The roots of holism in health

The term ‘holism’ was coined in 1926 by Jan Christiaan Smuts, a South African philosopher, military leader and prime minister, who used the term to argue that South Africa was greater in its entirety than its individual states (McEvoy & Duffy, 2008, p. 414). Smuts introduced the term as ‘the tendency in nature to produce wholes’, conveying the idea that the whole is greater than the sum of its parts (Pietroni, 1997, p. 9). Lawrence and Weisz (1998) conceptualised the various holistic perspectives that characterised anti-reductionist movements in medical practice in the West. In their edited book reviewing medical holism between 1920 and 1950, they described holism as an approach that can address individuals, the broad environment, and populations in various combinations. They argue that the term is relational; constituting a rhetorical claim that is made in opposition to approaches that are characterised as ‘reductionist’. So in fact, to understand holism we really need to first recall the critique of biomedicine as reductionist. The following figure, which I draw based on Lawrence and Weisz’s (1998) discussion of holism, describes the range of holistic perspectives in medical practice:

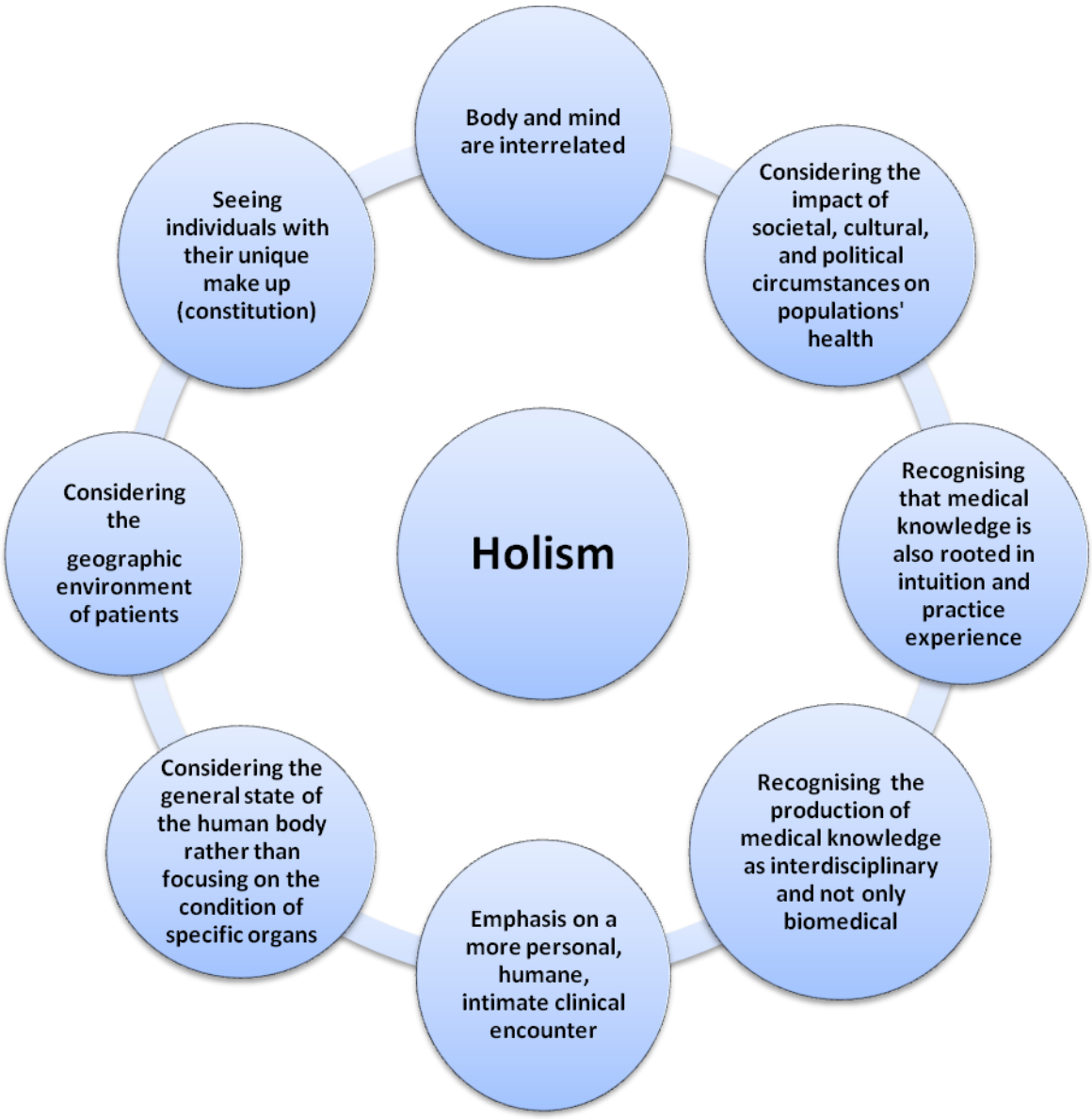


Figure 2: Holistic perspectives in medical practice according to Lawrence and Weisz (1998)

Perspectives that can be described as holistic in nature have existed since antiquity, and were always part of Western intellectual thinking (Lawrence & Weisz, 1998). According to Rosenberg 'holism is a fair description of the central and unquestionable worldview of medicine in the two millennia preceding the mid-nineteenth century' (Rosenberg, 1998, p. 336), before the mechanism-oriented, reductionist medical practice, started to strongly emerge and question mythical and vitalist notions. Modern holistic influences emerged as part of the Romantic

and Hegelian[21] movements in the early 1800s as a revolt against positivist thinking, and then found their way into disciplines such as philosophy, history and the emerging social sciences (Lawrence & Weisz, 1998, p. 5).

Holistic concepts also penetrated life sciences with the revival of the term 'vitalism', which is the assertion that living organisms cannot be understood only in materialist terms (ibid). Though not as strong a movement as in Germany (and to a lesser degree than in France), medical holism started developing in Britain in the late 19th century and early 20th century. During the first three decades of the 20th century, many elite medical practitioners were unhappy with the increasingly narrow specialisation in medical practice and the increasing reliance on, and subordination to, laboratory findings at the expense of a *clinical intuition* that was developed over time *through experience and practice*. This reductionist view was perceived by those critical medical practitioners as neglecting 'the unique and multidimensional understanding that grew out of a long-term doctor-patient relationship' (Rosenberg, 1998, p. 343). This critique of the clinical neglect of intuition and experience as part of medical practice is, as discussed in the next chapter, an important aspect of holistic thinking.

There were considerable debates in relation to holism within biomedicine long before the emergence of the medical counter culture. In fact there was a significant holistic movement in mainstream medicine in Europe between the two World Wars (Lawrence & Weisz, 1998). Amongst health professions contributing to a development of the holistic dimension of medical practices are nursing, social psychiatry, psychology, and parts of the public health movement (for example, social psychology), emphasising the mind-body interrelations and the interaction between the internal and the external environments of people (Rosenberg, 1998, p. 344). Despite its reductionist tendencies, discussions about holism and efforts to reduce the reductionist tendencies inherent in biomedicine are taking place in mainstream medical care (Paterson & Britten, 2008, p. 265). For example, holism is much discussed in nursing education and is an integral part of nursing practice (McEvoy & Duffy, 2008). It is also a significant part of contemporary public health,

[21] Hegel was a German philosopher whose ideas dominated German intellectual life in the 1840s (Bilton et al., 2002, p. 476).

health promotion, social medicine and epidemiology (Hill, 2003; Lawrence & Weisz, 1998, p. 17; Naidoo and Wills, 2000). Moreover, a holistic approach to practice is a core competency in medical general practice. For example, 87% of 1,916 Scottish GPs considered a holistic approach as an essential component of their practice (Hasegawa, Reilly, Mercer & Bikker, 2005).

So far, I have described the emergence of holism in medical practice, but without touching on the actual meanings of holism. In the next section I will present the various holistic claims and holistic concepts that are part of the holistic discourse in healthcare, first in medical practice in general, and then as a central theme of CAM's premise.

2.4 Conceptualising holism

Holism is a complex concept and one that is difficult to pin down. It refers to many dimensions, from scope of practice to the nature of medical knowledge, or as suggested by Scott (1999, p. 141), it refers to a 'wider self' or a 'wider world' as well as reformulating the nature of the practitioner/patient relationships. It is possible to consider medical holism using several different angles. For example Rosenberg (1998) offers a historical angle over medical holism by describing four holistic perspectives in medical practice that are structured by particular historical actors and by moral and social agendas. He refers to these perspectives as 'historical holism', 'ecological holism', 'organismic holism', and 'worldview holism'.

Historical holism refers to the drawing on historical biological and social observations of human development. Here, the observation of human health is based on an evaluation of the way individuals over time adapted and responded to life circumstances. This perspective is linked to the concern with 'diseases of civilisation' (diseases that emerged in Western societies through the processes of modernisation, sedentary lifestyle and urbanisation) and the spread of chronic diseases that are linked to a modern lifestyle. Rosenberg describes a certain sentiment attached to historical holism, that of 'world-we-have-lost-it holism',

which is seeing life as a kind of 'traditional village society'. For example, this holism involves perspectives such as that life used to be less intense and less stressful, life used to be more community oriented etc. Montgomery also describes this aspect of holism as a drive towards some sort of 'ideal community of self-reliant individuals who are able to get rid of the toxic dependencies of a damaged civilisation that exists at the heart of urban decay and assault' (Montgomery, 1993, p. 84).

The 'ecological holism' model is the focus on the body in a particular social and physical setting as in social medicine and public health (Rosenberg, 1998). Health is seen as resulting from both social and individual harmony, and populations' health is influenced by broad economic, social and physical environments. Ecological holism is different from historical holism in that it focuses more on certain groups rather than on individuals in a particular clinical context, and it involves a degree of social commitment to the wellbeing of groups and for the need to provide communities with supportive circumstances to maintain their health (for example increasing affordability or infrastructure of health in developing countries). In 'organismic holism' Rosenberg (ibid) refers to the way that for centuries the body was seen as an interactive unit that is altogether greater than the sum of its constituent parts and processes. This view has both religious and secular perspectives. Religiously, it demonstrates a spiritual divine presence in the way that the body functions. From a secular perspective our bodies and life processes are perceived to have more to them than being mere biochemical and biophysical mechanisms. In CAM this holistic notion is translated into the 'inherent healing wisdom of the body' which is the way that the body as a whole adapts to various circumstances and threats. For example the *Textbook of Naturopathic Medicine* describes six principles of naturopathy, the first one being 'vis medicatrix naturae' or 'the healing power of Nature':

> Nature acts powerfully through healing mechanisms in the body and mind to maintain and restore health. Naturopathic physicians work to restore and support these inherent healing systems when they have broken down by using methods, medicines, and techniques that are in harmony with natural processes (Bradley, 2006, p. 80).

Clinically such a holistic notion leads to an emphasis on the patient's uniqueness, often described as the patient's 'individual makeup' or 'constitution'. This in turn justifies the need for a stable and long-lasting practitioner-patient relationship that is maintained over time. Such close relationship allows the practitioner to thoroughly consider the patient and every aspect of her/his environment when making clinical decisions. This holistic perspective sees the doctor as a source of wisdom and insight and not merely a translator of laboratory findings. The fourth holistic perspective described by Rosenberg, is worldview holism, which overlaps with ecological holism. This term refers to the moral relationships between the body and society and the way that the state of society can be seen as contributing to peoples' disease-states. This worldview is at the heart of the critique of the achievements of reductionist biomedicine and of biomedicine as oppressive. For example, Ivan Illich's critique of biomedicine's harmful adverse effects and the way that it makes people dependent on it and lose their autonomy can be seen in the context of worldview holism.

2.5 Holism and CAM

So far I discussed holistic concepts in medical practice in general. In the next part of this chapter I will consider CAM's holistic discourse, and in particular, holistic concepts in acupuncture and homeopathy. Goldstein argues that because holism directly contradicts the centrality of dualism and reductionism in biomedicine, 'it is holism, most fundamentally, that separates alternative medicine from the premises of the conventional biomedical model' (Goldstein, 1999, p.44). Indeed, many authors use holism to characterise CAM, making reference to the holistic nature of CAM therapies in one way or another (Aakster, 1986 cited by Furnham & Vincent, 2003, p. 63; Bates, 2002, p.17; Coulter, 2004; Fulder, 2005, p.6; Goldstein, 1999, p.44; Hollenberg, 2006, p. 732; Jonas & Levin, 1999, p. 4; Micozzi, p.7; Mitchell & Cormack, 2005; Naidoo & Wills, 2000; Saks, 1997). Holism is also very commonly mentioned on the websites of practitioners, schools, and professional bodies.

Goldstein (1999) points to two fundamental holistic premises in CAM. The first is the belief in the interrelations between body, mind, spirit, and the larger environment. The second is the recognition in the unique makeup of each individual patient. The implication of these two holistic premises in practice is that each individual patient should receive treatment that matches her/his individual characteristics and unique constitution, and those CAM therapies have the capacity to provide such 'individualised' treatment. For example, the classical homeopaths will search for the one, most suitable, remedy to match the patient's unique presentation of symptoms. The traditional acupuncturist will look to identify the unique energy imbalance of the patient, and will chose the most suitable combination of acupuncture points, out of almost endless optional configurations, to match this imbalance.

Fulder (1996, p.4) describes similar holistic premises that, in his view, unite CAM therapies, although he emphasises in particular the therapies' focus on the restoration of health and recruiting the self-healing capacities of the body. Scott (1999), like Goldstein, argues that the growth of CAM reflects a rejection of the reductionist-dualistic approach of biomedicine, and the challenge of excessive biomedical power. She suggests that all holistic approaches in CAM share two common claims. The first is taking into account 'the whole person'. By that she refers to the consideration of all or some of the human dimensions, including body, mind, emotions, spirit, and the environment (although Scott does not explain what she means by the 'environment') including the social context. The second shared holistic notion is in the context of the relationship between the patient and the practitioner. Compared with conventional medicine, in CAM more responsibility is handed over to the patient, while the practitioner is more of a facilitator or a teacher rather than the agent of cure himself (ibid).

2.6 Wider self and wider world holism

I found Scott's (1999, p, 141) terms 'wider self' and 'wider world' holisms particularly useful in conceptualising the holistic discourse in acupuncture and homeopathy, and I will use these terms throughout this thesis. Broadly speaking, I

use the term wider self holism in reference to several holistic concepts that focus on the manifestation of ill-health *within* the individual patient, for example seeing body, mind and spirit as interrelated. An example of holism in the context of a wider world is viewing individuals in the context of their broader social and cultural environments. In figure 3 I have summarised the two opposing directions of the holistic discourse. The downward arrow is a summary of holistic concepts that can be described as the concern with the wider world around the patient and the position of patients in the context of the broad social, cultural and physical world in which they live. Examples for wider world concerns are the impact of social support, education, poverty, freedom of speech and freedom of expression or cultural beliefs over people's health.

Wider world holism also reflects the anti-oppressive critique towards biomedicine. It involves empowering patients and encouraging them to take an active role in the healing process. Here, the focus of attention in the medical encounter is shifting from the practitioner as the expert to the patient, and patients' personal biography and personal views are considered and listen to. Finally, wider world holism points at inter-disciplinary awareness and collaboration with other professional and academic disciplines. The upward arrow is a summary of holistic concepts which focus on the wider self, which is expanding individual capabilities in the context of the individual's 'inner-working', be it physical, emotional, and spiritual and energy levels, and the interrelations between them. This is done without much consideration for the broader environment (outside the immediate social living environment) and its impact of health. It involves consideration of the individual's unique constitution which is reflected in their body, mind and spirit interrelations, as well as treating the root-cause of health problems rather than treating symptoms. The combination of these wider-self notions allow the practitioner to promote the patient's natural healing forces and by that promoting healing from 'within'. I should note that the fact that the two holistic categories appear in the figure as opposing one another is not intended to suggest that they contradict one another. Rather it points at a certain tension between the *inward* nature of wider self holism and the *outward* nature of wider world holism.

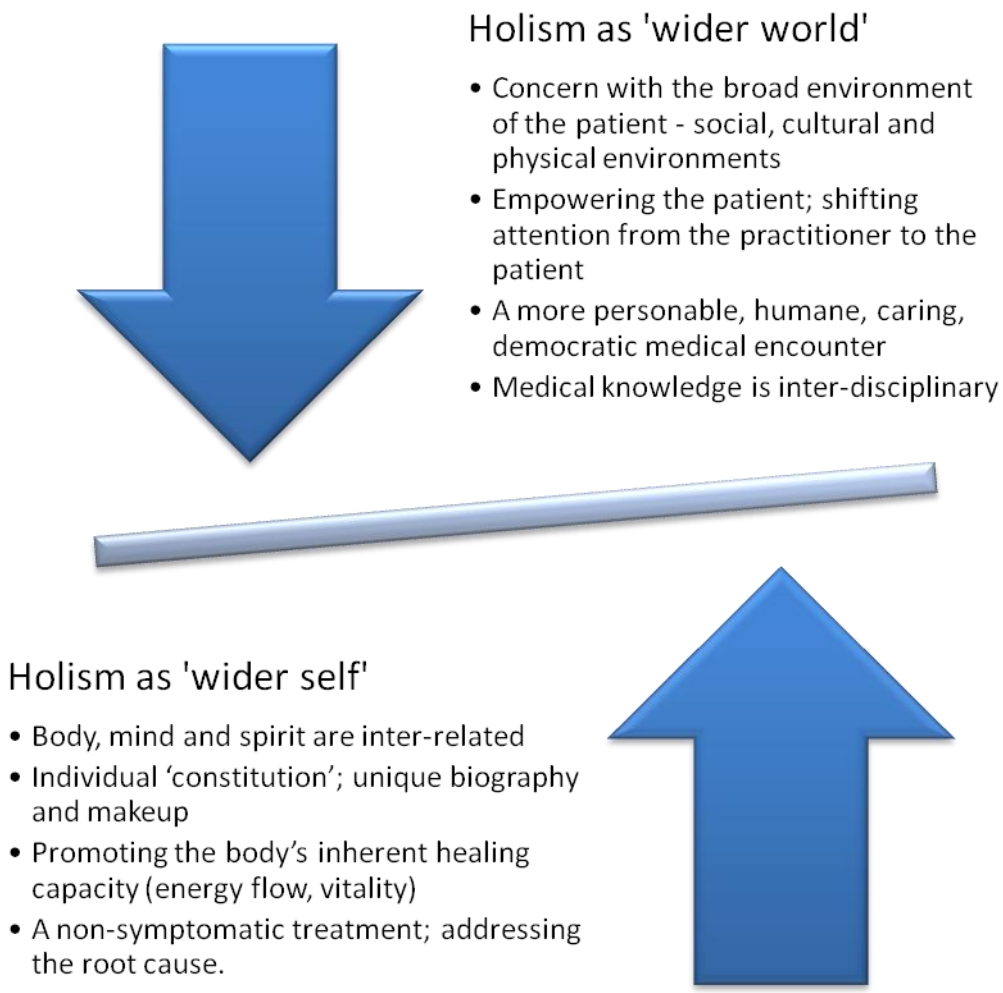


Figure 3: Wider self and wider world holistic claims (model developed from Fulder, 1996; Goldstein, 1999; Lawrence & Weisz, 1998; Rosenberg, 1998; Scott, 1999)

Acupuncture and homeopathy as holistic

The attachment of holism to both acupuncture and homeopathy is evident in the CAM literature, with acupuncture and homeopathy often being used as examples for various holistic concepts. For example Goldstein (1999) uses both homeopathy and Chinese medicine to demonstrate the individualistic nature of CAM, while Fulder (1996, p. 5) draws upon both therapies as examples of the way that in CAM, not only are body, mind and spirit viewed as interrelated, but also that individuals are seen in the context of their society. He argues that in both homeopathy and in Chinese medicine, 'emotional, psychological, and behavioural

signs are always included in diagnoses' (ibid). The question is how much such broad statements take into consideration the diversity of practice styles and theoretical approaches in acupuncture (Birch, 1998) and in homeopathy (Swayne, 1998) practice.

In discussing the diversity of approaches in acupuncture practice, Birch (1998), discusses holism in acupuncture practice. First, he points at the fact that Chinese philosophy never saw body and mind as separated from one another. However, while and most Western authors suggest that traditional models of acupuncture are holistic in nature (ibid), Birch argues that there are also some traditional acupuncture models and concepts that are clearly not holistic. He points at the way that some acupuncture treatment protocols and practice style are directed at treating symptoms and pathologies regardless of the 'whole person' (body, mind and spirit) or the individuality of the patient. Unschuld (1992, cited in Birch, 1995, p. 54) argues that 'the alleged antagonism between holistic-individualistic Chinese medicine and an ontological-localistic Western medicine is a drastic and misleading historical simplification of both traditions'. Like others (Peters, 1998; Pietroni, 1997) he points at the relationship between the diversity of practices in acupuncture and the varied degree of holistic engagement of the practitioner. Birch concludes his discussion by suggesting that it is not possible to portray all parts of traditional acupuncture as holistic, but clearly, many of the models do convey a holistic approach (ibid).

Similar issues can be noted in homeopathy. It contains many principles that justify describing it as holistic, yet the application of theory to practice is highly diverse and there are many approaches to, and styles of, practice. Swayne (1998) argues that the main holistic features of homeopathy are a) promoting the body's inherent healing capacity rather controlling it, b) provoking the 'vital force', and c) the individuality of the patient and her/his biography. He demonstrates how homeopathy is very diverse in several dimensions, including the philosophical approach of the practitioner and the prescribing strategy (finding the most suitable homeopathic remedy) that is employed in practice. The question is how much such diversity impacts on the degree of holistic engagement in homeopathy.

So far, throughout the chapter, I have presented a number of perspectives on holism by several authors, each providing a somewhat different angle. Such multi-focal presentation is helpful in grasping the depth and the multi-dimensional nature of holism. Moreover, the various historical and sociological perspective demonstrate that the holistic discourse is dynamic in nature, and that it is emerging in response to cultural, political, and historical events and circumstances. While the various 'holistic descriptions' demonstrate the fluidity of holism and the number of meanings attached to this concept, these descriptions also point at the functional value of holism in relation to the environment in which it is expressed. Some of the accounts are more historical in nature, demonstrating the evolvement of the concept over time in relation to medicine in general (Lawrence & Weitz, 1998; Rosenberg, 1998), or in the CAM/biomedicine historical context (Bates, 2002). The approach presented by Lawrence and Weitz and by Rosenberg is particularly useful in representing how, during the interwar years, significant movements of clinicians and scientists in Europe and North America were not indifferent to the reductionist critique of biomedicine. As part of larger social and cultural movement, they responded to increasing reductionism in biomedicine by creating holistic models of healing from within biomedicine. Fulder's (1996) and Goldstein's (1999) descriptions of holism are 'CAM specific'. Fulders' reference to holism in CAM is helpful in gaining an overview perspective on the way holistic concepts are included in the description of various CAM practices and theories. Goldstein's' work describes the holistic nature of many CAM as part of the broader political, social and cultural context in which it developed in North America, and the role it played as part of the medical counter-culture.

In the context of this thesis, Scott's work was particularly useful in 'making sense' of the multiple holistic attributes that are attached to CAM practice. As we shall see, Scott (1999) provided a useful analytical framework to the holistic discourse in CAM, by placing it critically in relation to the critique of biomedicine's 'dualistic logic'. She presented three 'holistic patterns' in CAM, and examined each in relation to conceptual dualism and the concern that clinical medicine reinforces social power. By that, she contributes to a structured, analytical consideration of

the various holistic claims, alongside the potential tensions that are part of the holistic discourses in CAM. In this thesis my intention is to use this perspective and develop it in the context of the challenges that are part of formalising NMQ acupuncture and homeopathy education.

2.7 Potential tensions in the holistic discourse in CAM

The initial sociological interest in CAM as an expression of anti-reductionist, anti-oppressive notions was followed by a second wave of literature which analysed these holistic claims more critically, highlighting several important tensions inherent in them. In the next part of this chapter I will examine this critique and the concerns it raises in relation to CAM practice.

Holism as a discourse of de-medicalisation and the problem of increased interpretive authority

Much of the critique of CAM as holistic focuses on the role CAM practitioners play along the 'medicalisation /demedicalisation continuum'. Scott's (1999) insightful analysis examines CAM in the context of different holistic patterns, while highlighting several difficulties in the implementation of these holistic claims. The first holistic model she describes is the 'biographical/expressive' holistic model which allows patients to describe their health concerns through a narrative reconstruction (ibid, p. 136). This model is well developed in CAM as demonstrated for example by Scott herself in relation to homeopathy (Scott, 1998), where the patient's personal biography is significant and essential in informing practice decisions. This pattern is not unique to CAM. It also characterises traditional branches of psychotherapy and medical sociology. It allows patients to re-construct their ailment and express it in the context of personal, environmental, social and cultural perspectives. Here, often in contrast to biomedicine, patients are encouraged, and have room to, express themselves (Scott, 1999).

While this approach seems far more holistic in widening the scope of the patient's health, it involves certain potential difficulties. Firstly, the practitioner in such an encounter gains profound interpretive authority to 'make sense' of the patient's biography, and in so doing maintains the same powerful position that is so often argued against in the case of biomedicine. For example the homeopathic practitioner may link a certain emotional aspect of the patient's intimate biography with a certain behavioural pattern, which will determine the homeopathic remedy being prescribed. By doing so, arguably the practitioner gains a powerful position to make interpretations over the patient's emotional life.

The other concern is that while it is attentive to the patient's perspective in the context of her/his perceived psycho-social environment, such an encounter over-medicalises ordinary social behaviours of the patient and brings normal events, encounters, and behaviours, into the medical arena (Baer et al., 1998). For example, by placing an emphasis on the patient's state of mind and suggesting that the patient should develop a positive attitude towards life in order to improve her/his wellbeing, a patient may start considering this dimension as another health concern, right next to eating healthily or doing physical exercise. Lowenberg and Davis (1994) describe the way CAM therapies often encourage individuals to take responsibility for their own health through information seeking, making dietary changes, reducing stress, and exploring emotional and spiritual dimensions. In so doing, CAM shifts power from the practitioner to the patient while reducing the distance between the two and so creating a more egalitarian exchange.

Therefore CAM represents a cultural shift from medicalisation towards de-medicalisation in that it dilutes at least some of the powerful position of the 'expert doctor' in favour of empowering the patient. However, as argued by Crawford (2006, p. 410), this individual responsibility and preoccupation with health can turn the concern with health into such a burden that there is little room for anything other the quest for personal wellbeing:

> Health became a responsibility so demanding that there would be little room for responsibility beyond the quest for personal well-being....The

> social cynosure of health saturates the imagination with worries and tasks. Expansively, health becomes the 'what is to be done' of private life (Crawford, 2006, p. 411).

Moreover, in the more radical form of holistic health, individuals are often presented as choosing to be ill. For example, on several occasions during my naturopathy study in Israel we were recommended to purchase the book *You Can Heal Your Life* by Louise Hay (Hay, 1988). In this best-selling book Hay argues that by limiting our ability to express our beliefs and thoughts, we often cause ourselves illness. She suggests that we are '100% responsible' for creating our future with our thought patterns and that by changing the way we see ourselves and think of ourselves we can improve our health. Moreover, she blames patients for preferring to stick to their negative feelings than really wanting to get well:

> We are each 100% responsible for all our experiences. Every thought we think is creating our future... Everyone suffers from self-hatred and guilt. The bottom line for everyone is 'I'm not good enough'. It's only a thought, and a thought can be changed. Resentment, criticism, and guilt are the most damaging patterns. Releasing resentment will dissolve even cancer. When we really love ourselves, everything in our lives works. We must release the past and forgive everyone. We create every so-called illness in our body (Hay, in Goldstein, 1999, p.144).

Coward (1989) comments that such views, which place the responsibility over health on individuals, without considering the impact of society and the 'external' environment, are extremely common. Moreover, she argues, the impact of external pressures and the stresses that modern life places on individuals are only secondary to the notion that individuals are responsible for their health:

> It is as if disease has itself has itself become a kind of morality, demonstrating the level of the individual's personal control over their life (Coward, 1989, p.92).

The critique that I have described so far, was in the context of what Scott (1999) referred to as the biographic/expressive holistic model. In the next section I will discuss a critique in relation to health and the broad environment of patients, or what Scott refers to as the 'ecological/epidemiological' holistic model.

Holism and the broader environment of patients

A second holistic model Scott describes is the 'ecological/epidemiological' model. This is the focus of preventative medicine, social inclusion, and environmental concerns surrounding individuals' and communities' lives (Scott, 1999, p. 138). This approach, characteristic of the new public health movement, is at the centre of the debate between what is described as the 'narrow' and 'broad' approaches to public health (Margetts, 2004, p. 4). This holistic model reflects awareness of social and environmental issues, and in this respect it represents an intensively holistic view which is described as a 'broad' public health view. We can link this view with 'wider world' holism.

However, it is argued that there is a tendency in CAM practice to focus on individualistic concerns relating to behaviour, education and lifestyle choices such as not to smoke, not to consume alcohol, not to abuse drugs, eat healthily and exercise, or what can be described as 'self-control'. This tendency is described as a 'narrow' approach to public health, and is in fact moving *away* from 'wider world' holism. It was well-argued by several researchers in relation to CAM (Baer, 2003; Baer et al., 1998; Lowenberg & Davis, 1994; Salkeld, 2005) that by focusing on educating the individual patient without paying attention to the social, cultural, economic, political, or geographic environments in which patients operate, in practice CAM tends to engage in a rather limited holism and follows the 'narrow' approach. Baer reflects:

> Despite the growing recognition that many health problems are related to stress in the workplace, socioeconomic inequities, racism, and environmental pollution, the individualistic approach of most holistic health practitioners precludes the possibility of forming social movements to address these problems through collective efforts. ...the holistic health movement, much like the popular health movement in the 19th century as well as a rejuvenated biomedicine that emphasizes healthier lifestyles, engages in a form of moralism that places the onus of responsibility for wellness on the individual rather than the larger society (Baer, 2003, p. 240).

In fact, Baer links the critique over CAM's lack of engagement with the broad environment of patients with the critique of 'victim-blaming' and placing responsibility on individuals. Both can be seen as lack of sociological engagement by CAM practitioners.

Holism as a spiritual model: the lack of clarity in describing holism and the 'scientification' of CAM

A third kind of holistic model discussed by Scott (1999, p. 139) is the 'spiritual holistic model': the interrelations of body, mind and spirit. This model, unlike the previous two models, is a metaphorical or spiritual model rather than social or political one. Scott argues that while there is significant reference to this model in CAM, there is vagueness and a lack of clear conceptualisation of it. For example, while the body/mind relationships seem to be quite well addressed in the literature, the inclusion of 'spirit' in this equation is often unclear. As a result, while this model contests the body/mind dualism and the reductionist-materialistic nature of conventional medicine, it makes it difficult to understand *how* exactly it challenges the biomedical model (ibid).

Several commentators discuss the way that some CAM practitioners ground their knowledge claims, suggesting that CAM knowledge is often presented using metaphysical and moral claims, but frequently without trying to demonstrate such claims (Peters, 1998). At the same time, some CAM practitioners use the credible position of biomedical knowledge in society to boost unscientific claims of their practice, which is not surprising considering that CAM practice developed very quickly in an environment that is dominated by biomedicine (Keshet, 2011, p. 503).

In reviewing CAM texts, Montgomery argues that CAM uses a mixture of ideas that do 'not really attempt to comprehend disease in any concrete, material sense'

(Montgomery, 1993, p. 72). He suggests that CAM practitioners tend to place the patient between metaphysical and moral forces, without aspiring to define, describe or interpret the meaning of 'true knowledge'. Such holistic discourse, he argues, is less concerned with evidence and proof than with the use of metaphors (for example 'vitality'), symbols (for example *yin/yang*), and lyrical descriptions (for example 'balancing emotions') as ways of proposing unseen agencies of healing and cure. Montgomery also presents several examples from CAM literature of what he describes as 'symbolic adoption', describing the borrowing of scientific words for metaphoric purposes:

> The most sophisticated authors on holistic medicine, in fact, frequently take up the "scientific" both in terms of language and style, mixing both into a discourse which remains allegorical in the end. The result is sometimes extremely interesting and remarkable, not the least for what it reveals about the relative failure of such mixing between symbolic and antisymbolic (technical) discourses. Such attempts, in short, produce an odd mixture, a kind of discursive colloid (Montgomery, 1993, p. 78).

This, I would argue, is a rather harsh criticism, at least in relation to some CAM. Therapies such as acupuncture and homeopathy are engaged with systematic philosophical and theoretical descriptions of disease conditions, albeit not scientific ones. However, while Professor David Peters, a conventional medical practitioner, osteopath, CAM educator, and the chair of the British Holistic Medical Association, cannot be accused of sitting in the 'anti-CAM' camp, he too asserts that it is important for CAM practitioners to maintain a critical stance towards their holistic claims and their holistic rhetoric (Peters, 1998). Like Montgomery, he argues that many of the claims made by CAM practitioners, such as 'toxins' and 'detoxification' in naturopathy or Chinese medicine, are metaphors[22], and that without demonstrating such claims they remain nothing more than metaphors.

In table 1 I have summarised the critique of the holistic discourse in CAM in the context of 'wider self' and 'wider world' holism. On the left column I have placed

[22] According to naturopathic principles, the accumulation of 'toxins' in the body leads to many chronic conditions and this requires encouraging the process of 'detoxification' via elimination-organs as the skin, the liver, the bowels and the kidneys. Also in Chinese medicine, disease such as eczema may be considered as a failure of the liver to organise metabolic processes, or as due to inadequate elimination (Peters, 1998, p. 141).

holistic concepts in CAM, and in the right column the corresponding concerns or tensions that the literature highlighted in relation to each holistic notion.

Table 1: Potential tensions in CAM's holistic discourse

Wider self holistic notions	**Tensions inherent in these notions**
- Body, mind and spirit are interrelated - Treating the root cause: considering the general state of the body rather than the specific condition or symptom - Promoting the body's inherent healing capacity rather than controlling the body - Consideration of individual's uniqueness, personal biography, constitution	- In practice many practitioners present their practice as suitable to treat specific conditions; some approaches to practice are more 'symptomatic' than others - Increasing the interpretive authority of the practitioner - Increased medicalisation of 'regular' day-to-day events - Patients are often overloaded with health-maintaining tasks which become physical and emotional burdens
Wider world holistic notions	**Tensions inherent in these notions**
- Concern with broad social, cultural, political, economic, and geographical environments of patients; also, concern with the availability, accessibility, affordability, acceptability of services - Empowering patients to gain control over their health; shifting attention from the practitioner's to the patient's perspective - A more personable, humane, caring, democratic medical encounter - Medical knowledge should be inter-disciplinary, not only biomedical; also, it should leave for practice-experience and intuitive knowledge.	- In practice CAM's focus is on individuals in isolation from their broad environment - 'Blaming the victim' approach is common in CAM, encouraging guilt, blame, and shame. - Practitioners often lean on the reputation of science and biomedicine to support unscientific claims despite an anti-reductionist rhetoric - CAM is mostly available in the private market and hence is not accessible or affordable

In this chapter I have discussed the roots of holism in health and the holistic discourse in CAM, alongside the critique of biomedicine as reductionist and dualistic as part of the medical counter culture. I have presented the various holistic notions in CAM in relation to 'wider self' and 'wider world' holism. The conceptualisation of holism in this chapter allows a better grasp of this rather fluid concept, enabling an exploration of NMQ acupuncturists' and homeopaths' holistic discourse. Moreover, I have discussed a number of tensions and potential limitations to some of the holistic notions in CAM, which are important to consider as part practitioners' narration of holism and in examining practitioners' awareness and reflectivity in relation to their holistic practices. In the past few decades, acupuncture and homeopathy have been engaged in professionalisation. This process has involved efforts to formalise and standardise training and education, including validation by higher education institutions (HIEs). The holistic discourse which I discussed in this chapter provides a useful angle to examine the challenges that are part of formalising NMQ acupuncture and homeopathy education, and the strategies practitioners use to negotiate these challenges. In the next chapter I will discuss professionalisation trends in CAM, using the perspective of closure strategies, and the challenges and tensions that are part of formalising the therapies' education. As we shall see, the holistic nature of the therapies is challenged to this process, and practitioners are required to negotiate their holistic discourse in relation to these challenges.

Chapter 3

Professionalisation, holism, and regulation in acupuncture and homeopathy

As discussed in the previous chapter, many CAM therapies, including acupuncture and homeopathy, are founded on theoretical perspectives that are not consistent with those of biomedicine. In the past few decades, like several other CAM practitioners, NMQ acupuncturists and homeopaths in the UK have been engaged in efforts to increase their professional status and move closer to the mainstream via professionalisation (Cant & Sharma, 1996a; Saks, 2005b). Cant and Sharma used the term professionalisation in relation to CAM as 'a type of *occupational change and formation* [emphasis in original] that involves unification, standardisation, and the acquisition of external legitimacy (Cant and Sharma, 1996b, p.157). These efforts to increase practitioners' status in the healthcare market involve attempts to legitimate their knowledge claims. However, holistic and non biomedical claims that are part of the therapies' knowledge are contested in an environment that is dominated by biomedicine (Hirschkorn, 2006, p. 548), and there is a question how CAM practitioners maintain their distinct and unique philosophies and practices in a regulatory framework (Boon et al., 2004). The aim of this chapter is to conceptualise the relationship between acupuncture and homeopathy's holistic premise, and the formalisation of expert knowledge that is part of the professionalisation efforts of both therapies.

The theory of professionalisation has to do, in one way or another, with how knowledge is presented, since the claim for an expert position is central 'in the acquisition of trust, legitimacy, autonomy and a monopoly' (Cant & Sharma, 1996a, p. 586). A significant part of the professionalisation efforts of acupuncture and homeopathy and the other 'big five' CAM is education (Wiliams, Stone & Lee-Treweek, 2005), and some sort of standardisation of professional knowledge. This includes codification of knowledge bases by development of training schools and syllabi (Cant, 2009). The standardisation of education, however, may present significant challenges to the transmission of holistic knowledge claims in

acupuncture and homeopathy, and is viewed by some practitioners as diluting the philosophical base of their practice (Clarke et al., 2004).

In the earlier chapters I described the main actors in the field under investigation. I discussed the critique of biomedicine, the re-emergence of CAM with its holistic premise, and literature that highlighted potential limitations in CAM's holistic claims. Efforts to professionalise, as we shall see, involve a significant degree of adherence to mainstream processes. It is intriguing, then, to identify whether the therapies maintain their holistic premise during a process that: (a) involves moving closer to a biomedical-dominated mainstream; (b) requires the standardisation and codification of a largely non-biomedical knowledge; and (c) is dominated by mainstream academic and professional agencies.

3.1 Professionalisation

According to Turner (1995), the concept of *professionalisation* emerged as an attempt to reconcile two sociological traditions. The first professional perspective sees professions as a stabilising force in a capitalist society based on disinterested service and effective neutrality. In line with this perspective, Parsons (1991) viewed professionalisation as a process which provides professions with the knowledge and the skills to maintain social order and, in so doing, meet the functional needs of society. The second sociological tradition is more critical, arguing that professions are largely driven by monopolistic interests and are shaped by the bureaucratic forces of contemporary capitalism. In turn, occupations which succeed in achieving professionalisation gain privileged social and economic positions in that society (Saks, 2003b, p. 224).

The trait models of professions differentiated professions from occupations based on a list of characteristics of a profession (Saks, 2003b). Commonly cited is Millerson (1964) who viewed the degree to which an occupation is a profession on the basis of a number of characteristics: having a theoretical knowledge underpinning the professional skills; specialised training and education; formal examinations testing members' professional knowledge; the development of a

professional organisation within the occupation; the following of a professional code of practice, and having a moral obligation and an ethical code of conduct. This approach was criticised by a number of scholars including Freidson (1970), who pointed at the limitation of such a description of professions in that it does not reflect the social, economic or political conflicts surrounding the organisation of professions, or the political motivations driving some professional groups (Nettleton, 1995, p.196). Moreover, as Saks (2003) points out, this model is weakened by the fact that the elements are theoretically unrelated. A more critical view sees professionalisation as a strategy of occupational control which is shaping the relationships 'between experts, patrons, and the client' (Turner, 1995, p.133) and which is a product of specific socio-political processes (Parkin, 1974).

3.2 Strategies of social closure

Social closure refers to the way occupations seek to regulate market conditions in their favour, minimising competition from others by employing strategies which restrict access to a limited group (Parkin, 1974). They do so by closing off entry to the profession to all but those that are 'suitably qualified' and who meet the conditions determined by the occupational group (Saks, 2001). This concept originates from Max Weber's interest in the way social groups gain and maintain privileged positions in society, and the way in which a social class closes itself off and builds boundaries separating its members from other groups (Parkin, 1974). In this process occupational groups who enjoy class related advantages such as high income, high status or political influence, use these advantages to sustain their privileged position while excluding others from it. In the context of social closure, professions are occupations with a legal monopoly of social and economic opportunities in the market place based on credentialism (Macdonald, 1995). Credentials are degrees, diplomas, or certificates that are obtained from institutions whose positions are widely known and accepted (ibid, p. 161); for example, higher education institutions (HEI). Therefore, from the social closure perspective, professionalisation is based on establishing legal occupational monopolies in the marketplace to achieve privileges of income, status and power. Typically, professionalisation involves features as formalising educational programmes and creating codes of ethics to establish exclusionary social closure

– this is even if the profession cannot necessarily maintain high levels of altruism (Saks, 1999).

According to Larson (1980), maintaining occupational monopoly has three important dimensions. The first is the presence of a university system to provide a formal educational basis and systemic entry requirements. Such a system allows the production and maintenance of a body of esoteric knowledge which requires considerable interpretation in its application. Second, in order to maintain a clientele for its services, the profession will employ various exclusionary practices to subordinate or remove competing occupations. This process may require legislation; hence it involves support from the state. Third, it involves maintaining autonomy over the delivery of professional skills and over the relationship of the practitioner with the client at the point of work.

3.3 Social closure and professionalisation in CAM

The perspective of social closure is helpful in reflecting on the political nature of the marginalisation of CAM. As described in Chapter One (p.8), when eventually the 1858 Medical Registration Act was passed, it established a unified medical profession in the UK which won exclusive rights to the title of doctor, held a register of practitioners and provided the basis for self-regulation (Saks, 2003b). During the following years a number of health occupations were engaged in a long struggle with biomedicine and have gained a professional standing but at the expense of being formally subordinated to biomedicine (Saks, 1999)[23]. As Saks points out, 'as part of this process, each of these more recently accepted professions had to acknowledge that its fate was to be in the shade of orthodox medicine' (ibid, p.130). However, while being dominated by biomedicine, the new health professions had an advantage over alternative medicine practitioners of being part of mainstream healthcare and with it the benefits deriving from an improved social standing (ibid). Other competitors in the UK healthcare market, such as homeopaths and herbalists, could still practice under common law.

[23] These include midwifery (1902), nursing (1919), and later, in 1960, professions such as dieticians, occupational therapists, physiotherapists, radiographers and others (Saks, 1999).

However, a process of social closure to protect the new boundaries of the now officially recognised medical profession took place. This included attacks on CAM practitioners in mainstream medical journals describing CAM as unscientific and as wasting patients' money; the establishment of a professional code of ethics which limited collaboration with CAM practitioners and sanctioned conventional medical practitioners who practiced CAM; and finally, the blocking of attempts of CAM groups who tried to achieve professional organisation (Saks & Lee-Treweek, 2005). Several factors assisted the medical profession in maintaining authority over CAM and in downplaying CAM practitioners: the political lobbying of the pharmaceutical industry; inner-divisions within CAM and the lack of a common front by CAM practitioners; and most of all, the support of the state (Saks, 2003b).

However (as discussed in section 1.5) CAM re-emerged in popularity during the 1960s and 1970s as part of a medical counterculture, and although initially the popularity of CAM was strongly resisted, a significant change in the attitude of the medical profession in the UK towards CAM altered the circumstances (Clarke et al., 2004). The British Medical Association (BMA) moved from outright rejection in the 1980s to a selective cooperation with CAM a decade later by which

> ...professionalisation of CAM therapies is welcomed as long as their research base is centred on the narrow orthodox touchstone of randomised clinical trials, a significant biomedical component is included in their education programmes and they are locked into medically-controlled referral relationships (Saks, 2003b, p.234).

This process, combined with the increased popularity and public usage of CAM, brought forward a proliferation of CAM interest groups and CAM training courses, indicating a need for regulatory structures to support best practice and professional accountability (Wiliams, Jack & Ruso, 2004, p. 88). Following pressure from the state, the medical profession, consumers and from within the CAM therapy groups themselves, from the mid-1980s there has been an accelerated process of professionalisation of CAM therapies (Cant, 2009). Indeed, over the past three decades both homeopaths (Cant, 1996) and acupuncturists (Saks, 2005a) in the UK, as well as several other CAM practitioners, have been engaged in efforts to legitimate their knowledge claims. These efforts involved alteration of knowledge production and transmission on several plains: a shift from

a 'charismatic' teaching[24] and the apprenticeship model to more formal knowledge transmission structures, and increased scientific rhetoric in public presentation of CAM knowledge. In relation to homeopathy, Cant and Sharma (1996a) describe an alignment of CAM with the biomedical paradigm and the dropping of esoteric knowledge claims during the process of standardising homeopathy courses. Such efforts were most significant in the 'Big Five' therapies. Cant (2009) names the following professionalisation strategies in CAM: the development of training schools and syllabi; efforts to unify the many disparate groups of practitioners and to establish professional bodies with a register and codes of ethics which can be seen as the beginning of a social closure strategy; the inclusion of medical sciences in training; and attempts within several groups to temper their knowledge claims. Overall, the therapies were moving away from pluralism and were increasingly characterised by uniformity (ibid, p. 187). The professionalisation process involved calls for professionalism in CAM such as calls to protect consumers from harm and guarantee minimum standards of practice competency on the one hand, while practitioners maintain responsibility to protect their professional reputation as well as safeguard their practice (Wiliams, Jack & Ruso, 2004).

In 2000, the House of Lords Select Committee (2000, paragraph 5.1) explored regulatory avenues in CAM in the UK, including the leading professional bodies of both NMQ acupuncture and homeopathy, the British Acupuncture Council (BAcC) and the Society of Homeopaths (SoH). In relation to homeopathy, the Lords' view was that while homeopathy practice involves 'the fewest inherent risks', homeopaths are in a position of great responsibility since they see patients who might consider homeopathy as an alternative to a 'more proven' (in the reports' view) conventional therapeutic option. Hence, the report suggested, homeopaths and their users would benefit from tight regulatory structures ensuring educational standards and disciplinary procedures (House of Lords Select Committee, 2000, paragraph 5.63). These efforts, headed by the SoH, led to impressive professional

[24] By charismatic teachers I refer to the term used by Cant (1996) in her account of formalising homeopathy training. Cant used Weber's (1978 cited in Cant, 1996) concept of charisma which he consider as an extraordinary quality possessed by an individual, leading the individual to be treated as a leader.

developments in homeopathy (Sharma, 1996), but continue to be subject to ongoing debates within the homeopathy camp, as will be discussed in Chapter Six in more details.

In relation to acupuncturists, the Lords' report concluded that acupuncture is 'at a stage where it would be of benefit to them and their patients if the practitioners strive for statutory regulation', calling for the therapies to work towards such regulation (House of Lords Select Committee, 2000, paragraph 5.53). In February 2011, more than 10 years after the report was published, the House of Commons published recommendations for the regulation of practitioners of acupuncture (Department of Health, 2011). Despite NMQ acupuncturists' commitment and efforts to ensure statutory regulation, this report did not see an urgent need in such regulation, since, according to the report, acupuncturists had already established standards of safe practice. It appears as if acupuncturists' concentrated efforts to professionalise, ironically, prevented them from achieving statutory regulation. Yet, the BAcC states on its website that it remains fully committed to pursuing statutory regulation (British Acupuncture Council, n.d.).

Professionalisation efforts in CAM are not restricted to the UK. In Canada, for example, Kelner, Wellman, Welsh & Boon (2006) describe the current socio-political environment as sympathetic to the ambitions of popular CAM to professionalise. Such favourable climate, they suggest, results from the increasing demand for CAM services; the multicultural nature of the Canadian society which means that people are used to different kinds of treatment modalities; the increase in chronic health problems which leads people to seek alternative solutions for these problems; and a growing mistrust in mainstream institutions including medical and pharmaceutical institutions. Simultaneously, as in the UK, it seems that the medical profession is relaxing its resistance to CAM (while maintaining barriers at an institutional level), and some provincial governments in Canada have opened the door for some CAM to gain official recognition (ibid).

Despite significant internal fragmentation, CAM occupations such as naturopathy, acupuncture and Chinese medicine are working towards professionalisation (Boon et al, 2004), although, there are a number of limiting conditions: the therapies are still paid for privately, and there is a growing emphasis on evidence-based medicine and biomedical evaluation of CAM interventions, which maintains biomedical dominance over CAM (Kelner et al., 2006). There is also resistance for CAM regulation in the Canadian setting by established allied to medicine professions, to contain the acceptance of CAM groups and maintain their dominant position in relation to CAM (Kelner et al, 2004). This is despite the fact that CAM is practiced by a large number of medical doctors and allied to medicine practitioners. Kelner et al. (2006) explored the main strategies used by leaders of chiropractic and homeopathy in Ontario in their effort to professionalise. They identified four main professionalisation strategies: (1) improving the quality of educational programs, (2) elevating standards of practice, (3) developing more peer reviewed research, and (4) increasing group cohesion. One of the most striking strategies in the Canadian setting is the infusion of biomedical sciences and research to indicate that CAM practitioners are competent and reliable (Welsh, Kelner, Wellman & Boon, 2004).

In the following section I will to draw on Witz's (1990) model of closure strategies to discuss closure strategies in CAM, which I will then use, in the next section, to consider some of the challenges to the formalisation of education by NMQ acupuncturists and homeopaths. Witz describes professional projects as 'essential labour market strategies which aim for an occupational monopoly over the provision of certain skills and competencies in a market for services' (Witz, 1990, p. 675). In discussing the gendered politics of occupational closure, she provides a model of occupational closure strategies (presented in figure 4). The model, building on Parkins' description of closure strategies (Parkin, 1974), shows the power-relationships between the dominant group and the subordinate group in the occupational encounter using four strategic categories:

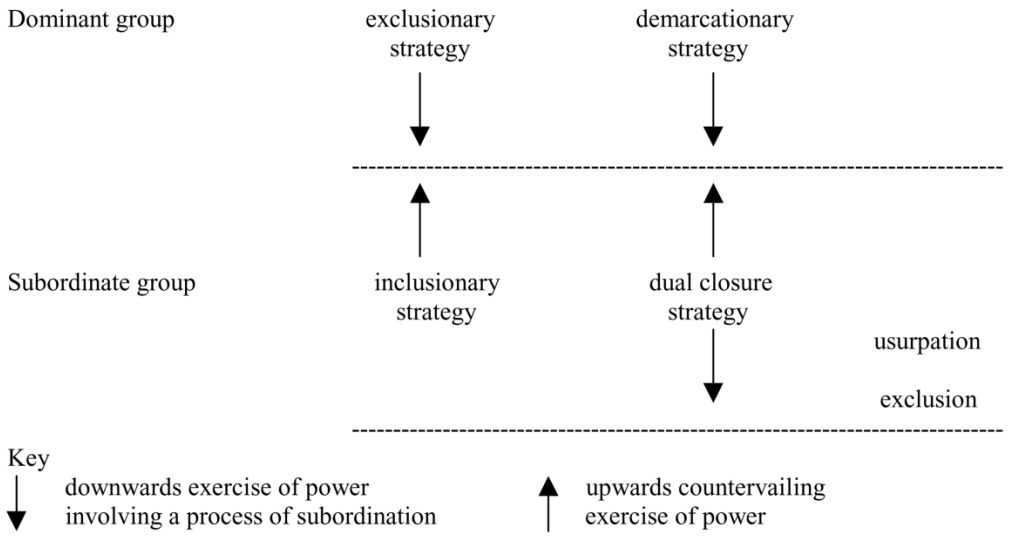


Figure 4: strategies of occupational closure (Witz, 1992)

Exclusionary and demarcationary strategies are used by the dominant social group towards the subordinate group. Exclusionary closure is the exercise of power by the dominant group by closing off the subordinate group's access to opportunities and resources, such as the creation of specific skills sets and entry credentials. This in return secures the dominant group with privileged access to the labour market. Research drawing on social closure theory suggests that CAM attempts to acquire legitimacy within mainstream healthcare have posed challenges to medical practice (Kelner et al., 2004), and in response, the medical profession has exercised occupational closure through exclusion and demarcation to control alternative medicine 'in a manner least threatening to the income, status and power of the profession' (Saks, 1999, 135). Here, the medical profession uses its powerful position in society in order to:

> Exclude CAM knowledge, often based on non-Western or holistic philosophies of care, from access to institutionalised research funding and mainstream undergraduate medical education (Saks, 2001, p. 120).

Demarcationary strategies are aimed at controlling matters of inter-professional boundaries of related or adjunct occupations in a division of labour. The term refers to the way occupational groups control and regulate the market of other

related occupations and create boundaries between them (Witz, 1990). Here, for example, the dominant medical profession may assign another professional group to be in charge of a specific and limited area of responsibility under the supervision of the medical profession. For example, nurses are assigned with 'care', pharmacists with the prescription of drugs, and physiotherapists with muscular-skeletal rehabilitation. There are a number of examples in the literature of the way CAM practitioners who work under the supervision of biomedical doctors in integrated care settings[25] are restricted to limited and isolated medical responsibilities such as emotional support or pain relief (Hollenberg, 2006; Shuval, Mizrachi and Smetannikov, 2002). Saks (1995) defined as 'tacit incorporation' the incorporation of acupuncture by biomedicine, as part of recent biomedical closure towards CAM. For example, the medical profession in Britain has moved from a position of rejection to the incorporation of acupuncture, by 'biomedicalising' acupuncture theory and practice (ibid).

Against these exclusionary and demarcationary closure strategies, the subordinate social group may use inclusionary or dual closure strategies. Inclusion strategies are used by social groups who are being excluded but seek inclusion against this exclusion. Hollenberg (2006) describes the use of such strategies as an attempt by the subordinate group to 'bite into' the advantages of the higher social group by seeking inclusion in the excluding occupation. A more complex strategy used by an occupational group as a response to being demarcated is dual closure. Here, the subordinate professional group may be engaged in a power struggle to resist being demarcated, while at the same time it may try to secure a degree of exclusionary closure and improve its professional status within the division of labour (Witz, 1990). In fact, while resisting being demarcated, the professional group establishes a new area of competence by employing its own demarcationary strategies. In the same way acupuncturists and homeopaths demarcate themselves from other CAM by relying on complex esoteric knowledge that requires significant training and the acquisition of practice experience. At the same time, however, acupuncturists and homeopaths resist

[22] By integrated care settings I refer to CAM practitioners who work with a conventional medical team in one way or another.

their exclusion from mainstream medical care by professional strategies such as regulating practice, formalising education, and increasing biomedical content in their training (Hollenberg, 2006; Walsh et al., 2004, p. 219). In this way they hope to increase their societal status and move closer to the mainstream. Such actions can be seen as inclusion strategies. A 'by-product' of this process is that by adopting such strategies, acupuncturists and homeopaths further demarcate themselves from other CAM (Hollenberg, 2006; Walsh et al., 2004, p. 219).

Boon et al. (2004) exploration of professionalisation in Ontario, Canada, point at both the usefulness as well and limits of the social closure perspective. While some degree of social closure will take place when self-regulation is achieved by CAM professions, it will not necessarily create a monopoly position. As in the case of acupuncture, which other medical professions (such as physiotherapy and medicine) will still have the right to include it in their practice. Moreover, medically qualified practitioners are able to use their status to claim superior position in practicing CAM, compared with NMQ CAM practitioners (for example Cant, Watts & Ruston, 2011). While social closure is helpful in explaining some of the success of CAM groups in working towards professional status, it is limited in explaining the interaction and dynamic *within* professions, and in considering processes other than exclusion in determining who gains control (Adams, 1998, cited in Boon et al., 2004).

Moreover, as argued by Cant, the professional status of CAM is uncertain, a situation which she describes as 'mainstream marginality' (Cant 2009). While several groups of NMQ CAM practitioners have engaged in professional projects in an effort to credentialise their knowledge base and close off their practice through regulation (Cant et al., 2011), this often involves tempering of knowledge claims and only minimal state recognition. Since the focus in CAM is on the experiential rather than on evidence base according to biomedical criteria, the focus of those practitioners' groups was on ensuring that practitioners are competent, ethical, and aware of the limits of their practice. As Cant et al. (2011) point out, social closure does not explain the way certain CAM groups continue to

pursue professionalism when formal reward is not granted, as in CAM's position of 'mainstream marginality'. Cant (2009) draws on the new sociology of the professions (Fournier, 1999; Evetts, 2006) to point at the discourse of professionalism as having an important role in increasing the professional status, enhancing trust and confidence in the individual practitioner, reassuring consumers that they are 'in safe hands', and self-policing of practitioners' work. According to Evetts (2006), professionalism in occupations and professions, points at

> ...the importance of trust in economic relations in modern societies within an advanced division of labour. In other words, lay people *must* place their trust in professional workers [....] and some professionals must acquire confidential knowledge. Professionalism requires professionals to be worthy of that trust, to put clients first, to maintain confidentiality and not use their knowledge for fraudulent purposes. In return for professionalism in client relations, some professionals are rewarded with authority, privileged rewards and high status (Evetts, 2006, p.134).

In the CAM context, Cant (2009) points out, professionalism serves not so much to increase status, but more as a way of helping to maintain a client base by unifying different modes of practice and 'asserting that a trustworthy "expert" is required' (ibid, p. 188). To locate the discussion over the holistic discourse in CAM and the challenge of formalising acupuncture and homeopathy education in the context of Witz's model, the next section will discuss the nature and application of professional knowledge using the work of Jamous and Peloille (1970).

3.4 Indeterminate knowledge, technical knowledge, holism and CAM

In order to discuss the unique nature of the holistic discourse in acupuncture and homeopathy and consider the challenges that are part of formalising the therapies' education, it is first useful to discuss Jamous and Peloille (1970) work on knowledge and indeterminacy. Their work centres on the way that the professionals' specialised knowledge creates the social distance between the expert/practitioner and the patient who is excluded from the esoteric knowledge of

the profession. Jamous and Peloille (1970) discussed the interplay between science and mystique that characterises the dominant form of medical knowledge, asserting that any occupation has a ratio of both 'ingredients', conceptualising it as a ratio between 'indetermination' and 'technicality' (I/T ratio). The I/T ratio expresses the possibility of transmitting, by means of apprenticeship, practitioner's control of the intellectual or material instruments used to achieve a given result. The technical (T) knowledge are the techniques and transmissible rules, described as 'the part played in the production process by "means" that can be mastered and communicated in the form of rules' (Jamous & Peloille, 1970, p. 112). Indetermination (I) are qualities of producers of professional skills. In the context of medical care, in accentuating indetermination, it is inherent in 'the clinician's emphasised individual and social potentialities, experience, talent, intuition, etc'. (ibid, p.139). These attributes are assessed and evaluated by existing members of the professional group. While professions have a need for a body of formal rational knowledge, at the same time, this kind of knowledge which can be codified and standardised, becomes more accessible to the public and to people from outside the professional group and this may undermine the privileged position of the profession. Therefore, those occupations that move towards a status of a profession need to be high in indeterminate knowledge, i.e. high I/T ratio. Overall, a high I/T ratio enable members of a profession to claim professional judgement and place their actions and decisions beyond the scrutiny of the lay public (Macdonald, 1995, p. 165). According to Jamous and Peloille, the medical profession, while grounded in technicality, is typically characterised by a high I/T ratio. In the interests of maintaining professional status, the medical profession consciously engage in a strategy of affirming the esoteric basis of clinical practice in order to avoid its routinisation and hence defend its privileged position to the lay public and to other occupational groups. They suggest that

> ....to valorize clinical medicine is to valorize the potentialities and the talent of the producer in obtaining the result; it is to make the quality of the result depend *less* [my emphasis] on techniques and transmissible rules than on always particular and hazardous relationship, 'the coming together of conscience and confidence' as the majority of doctors love to repeat (Jamous and Peloille, 1970, p. 140).

As Turner (1995, p. 133) comments in discussing Jamous and Peloille's work, where the knowledge of the profession is grounded in natural science, this knowledge can become standardised and subject to external control. The barrier protecting the profession from such routinisation and from being more accessible to externals is constituted by the indeterminacy of knowledge. This kind of knowledge, with its unique mystique, suggests that certain professional attributes and competencies cannot be systematically standardised. According to Johnson (1982), the deliberately esoteric character of professional knowledge, described as the 'mystification' of this knowledge, is differentiated from the technical complexity of professional knowledge. The higher the indeterminacy is in the professional relationship, the greater the social distance between the professional and the client, leading to greater dependency of the client. As pointed out by Cant et al. (2011), biomedicine ensured its dominant position by 'successfully monopolising the right to make discretionary judgement about the application of knowledge in situations which are of high risk because there is indeterminacy concerning both the interventions and the outcomes' (p.530). When the clinical situation is more quantifiable and predictable, involving more 'technicality', interventions are delegated to other subordinated health care professions (Jamous & Pelloile, 1970) such as nurses, midwives or physiotherapists.

In relation to CAM, Clarke et al. (2004) suggest that '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' (2004, p.330). Hirschkorn (2006) highlights the concepts of holism, vitalism and individualism - which are central to many CAM, as the bases for CAM's esoteric knowledge, suggesting that CAM generally (while recognising the diversity in CAM practice) is 'extremely' high in I/T ratio. Using terms previously used by Baer at al. (1998), she refers to opposing trends within the CAM community: on the one hand 'the professionalisers' who lead towards lower I/T ratios (downplaying the degree of indetermination), and on the other, the 'counter-culturalists', who wish to maintain higher I/T ratios (emphasise the indeterminate nature of practice).

In figure 5 (below), I drew on the work of Jamous and Peloille (1970), Witz (1990), and Cant and Sharma (1996a), to conceptualise the dilemma that acupuncturists and homeopaths face in relation to the transmission of knowledge as part of formalising their educational structures:

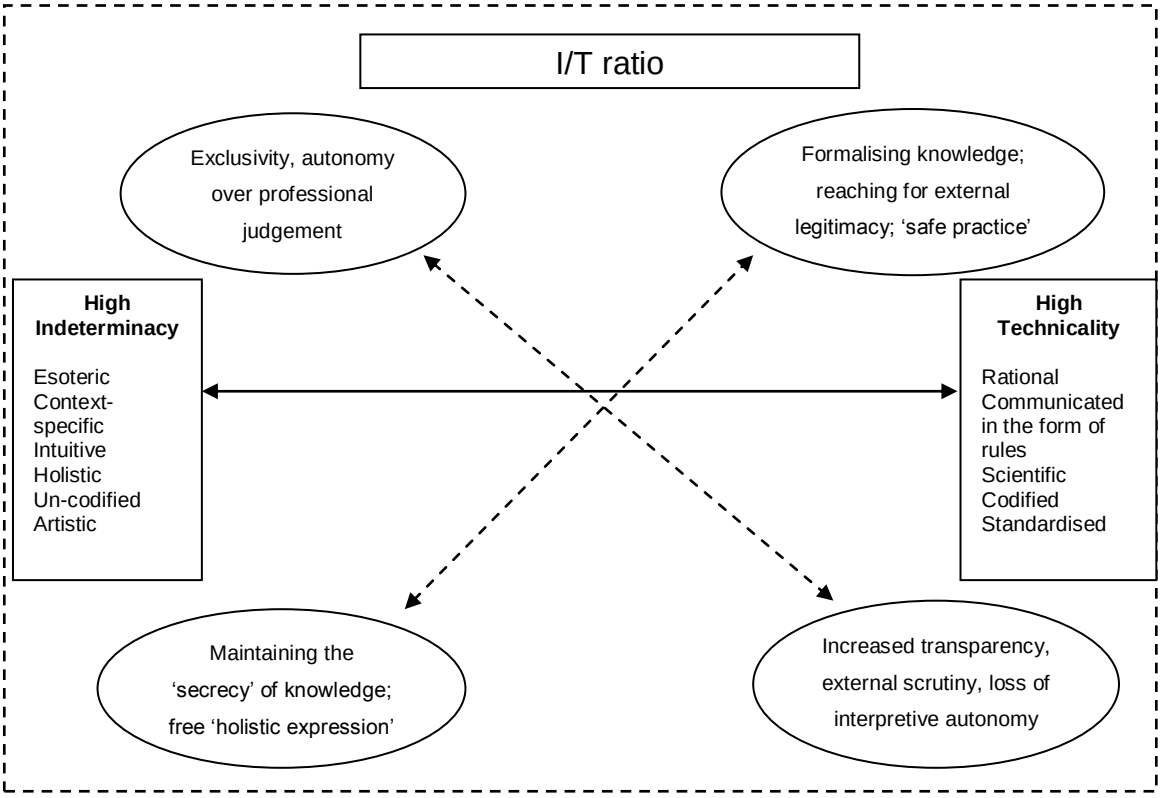


Figure 5: summary of the dilemmas in acupuncture and homeopathy in relation to the formalisation of education (drawing on Cant & Sharma, 1996a; Jamous and Peloille's, 1970; Witz, 1990)

Formalising acupuncture and homeopathy education can be seen as a strategy of inclusion into the mainstream, increasing the therapies' external legitimacy or what is often described as 'mainstreaming CAM'. This means that the therapies' expert knowledge will be more standardised and less exclusive as a result, becoming more technical - and lower in it I/T ratio. This, in turn, may help distance practitioners from 'unqualified practitioners' and get lay, medical and state legitimacy, although, it is suggested (Cant, 2009), that the degree to which this really happens is limited. The process of formalising education brings with it a concern that expert knowledge will become more transparent, and as a result more open to other professions as well as more vulnerable to attacks. In contrast,

resisting the process of formalising education and with it the increased codification and standardisation of expert knowledge, means that practitioners demarcate themselves from biomedicine by protecting their knowledge as distinct from biomedicine, trying to maintain the 'secrecy' of CAM knowledge. The tension is between, on the one hand, becoming professionalised and formalised, thus more transparent in an effort to increase the therapies external legitimacy and societal status and, on the other, protecting the holistic nature, the 'mystique' and secrecy of practice. For example, Welsh et al. (2004) discussed, in relation to CAM, the relationships between knowledge claims of occupations as a way of determining their jurisdictional boundaries:

> For CAM, it seems that those factions that are able to position their knowledge claims in a way that can be seen as most compatible or aligned with the dominant knowledge claims of medicine have the greatest chance of gaining social closure (Welsh et al., 2004, p. 219).

Another example for the tension between standardising knowledge and losing the unique nature of esoteric knowledge in that process is also evident in Cant and Sharma's (1996a) discussion of British homeopaths. While homeopaths tried to distinguish their knowledge from other healthcare practitioners by tempering their knowledge claims and formalising education, such process carries a risk of alienating patients from homeopathy, not finding what attracted them to homeopathy in the first place. I will return to this discussion in the empirical chapters of the thesis. I will now move on to discuss the process of formalising CAM education, and the challenge it brings in relation to the holistic nature of acupuncture and homeopathy practice.

3.5 The formalisation of the acupuncture and homeopathy education and the role of HEI

One of the benefits of professionalisation and the establishment of accredited programmes of education and research is achieving safer and higher quality client service through the development of codes of conduct, in an area of practice that involves potential health dangers (Saks, 1999). Indeed, one of the areas highlighted by the House of Lords Select Committee's report was the need to

increase the standardisation of CAM education and training in partnership with HEI (see section 1.4 in this thesis). Williams, Stone and Lee-Treweek (2005) point to the essential link between formalising education, including external accreditation of courses, and the future of professional projects in CAM:

> Certainly formal educational approaches (which are increasingly seen as requiring external accreditation) are one of the hallmarks of professionalism, along with effective regulatory structures. For CAM therapies seeking professional status in the eyes of the government and the general public, the way in which their practitioners are trained is increasingly recognised as an area that requires formal structures (Williams, Stone & Lee-Treweek, 2005, p. 28).

Partnership with HEIs can help ensure that acupuncture and homeopathy knowledge is delivered at the same standard as that of other professions that are members of the Health Professions Council (HPC)[26], and to which these two therapies aspire to belong. HPC regulated professions such as physiotherapy, radiography, paramedics, operating department practice, social work and others are taught within HEI (Health professions Council, n.d.). Moreover, through collaboration with HEI, it is possible to promote research and increase the evidence base for therapies like acupuncture and homeopathy (Saks, 2005a). Hence there are clear advantages for acupuncture and homeopathy in collaborating with HEI to enhance their professional standing in society while at the same time increasing their position in relation to other CAM.

It is, however important to highlight a number of concerns in relation to the formalising and standardising of CAM education. From the perspective of social closure, this process can be seen as promoting occupational self-interest rather than an altruistic concern for the broader public, as can be seen in the way that the medical profession responded to CAM (Saks, 1999). Moreover, Saks suggest that developing an expert position through standardising CAM training may structure an 'expert' profession which will increase the gap between the practitioner and the patient, against the holistic aspiration of many CAM to maintain a more egalitarian patient-practitioner relationship. Moreover, Saks

[26] The HPC (Health Professions Council) will change its name to HCPC (Health and Care Professions Council) from August 2012.

(2003b) points out that the professionalisation of CAM is welcomed by the medical profession as long as CAM's research base is centred on randomised clinical trials and as long as significant biomedical components are included in the educational programmes. By that, he argues, such strategies of incorporation are used to minimize the threat CAM poses to the power and dominance of the medical profession. For example, the Lords' report (2000) on CAM clearly highlights the aforementioned elements in its recommendations for acupuncture and homeopathy training. Another concern over standardising CAM therapies' education is raised by Clarke et al. (2004), who describe practitioners' fear that standardisation across courses may lead to lowering the standard of practice and to a lower common denominator and basic standards across courses.

In the case of acupuncture, the BAcC developed an accreditation process for acupuncture courses via the British Acupuncture Accreditation Board (BAAB), which sets educational standards for acupuncture. There are currently nine accredited acupuncture courses that meet the standards and criteria set out by the BAAB and the BAcC (British Acupuncture Accreditation Board, n.d.). All nine courses are at BSc (Hons) level and are either taught or accredited by British universities. It should, however, be noted that in 2010, one well-established accredited college stopped trading, and that two of the current accredited colleges are not recruiting new students.

In homeopathy, after years of teaching without formalised knowledge structures, homeopaths started to establish a clear professional identity by closing off their profession through the introduction of course content criteria and entry requirements (Cant & Sharma, 1996a). Despite continuous debates within homeopathy, the SoH formalised training, introduced core curricula and a course accreditation process (ibid). On its website, the SoH lists accredited courses that 'have completed the full recognition procedure and fulfil the required criteria for institutional and educational standards and for Clinical Education'. Fourteen courses are currently on the accredited list, although in 2010 three university BSc (Hons) Homeopathy courses stopped recruiting new students, leaving only one university validated BSc (Hons) in homeopathy. It is likely that the current decline

in university validated homeopathy courses has to do with persistent attacks on homeopathy by a group of academics and scientists who oppose the teaching of homeopathy by HEI (Corbyn, 2008). I will now discuss some of the challenges that are part of formalising acupuncture and homeopathy education, including the fear of losing the holistic ideology of practice.

Practitioners' concern about losing their 'performative autonomy' and the holistic nature of their practice

The House of Lords Select Committee's recommendation to regulate CAM professions was not free of debate. Lee-Treweek describes practitioners' ambivalent feelings in relation to the regulation of their practice:

> [Regulation of CAM therapies is a] controversial issue that often divides practitioners of particular modalities, whilst some wish for a regulation route that mimics the path of orthodox healthcare groups, for others regulation smacks of control and the quashing of creativity and spontaneity (Lee-Treweek, 2005, p. 212).

Moreover, from the practitioners' perspective there is a concern that regulation may restrict the intuitive, artistic side of their professional knowledge and remove the holistic nature of their practice. The Prince of Wales's Foundation for Integrated Health discussed this concern:

> It is probably true to say that many CM [complementary medicine] practitioners are concerned that regulation could be restrictive and inhibit innovative and holistic practices. …In a small pilot study carried out by the foundation in 2002 to discover practitioners' views about regulation, eight out of 12 practitioners interviewed said that they were concerned that regulation would 'restrict their freedom to practice intuitively' (Wiliams et al., 2004, p. 90).

Standardising a curriculum and codifying common criteria against which the competency and safe practice of the individual practitioner are measured is key in ensuring that a member of the professional group is a qualified and safe practitioner, distinguishing such a professional from an incompetent and unsafe

one (Clarke et al., 2004). This process requires formal processes, including formal guidelines, accreditation procedures, and disciplinary mechanisms (ibid). Clarke et al. (2004) argue that this is a challenging endeavour in CAM therapies, including acupuncture and homeopathy, because of the indeterminate and artistic nature of the therapies' knowledge. For example homeopathy:

> 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 (Clarke et al., 2004, p. 335).

Examples of this challenge in acupuncture are the student's ability to assess a patient's *qi* flow or *qi* imbalance, evaluate the energetic relationships between the five elements and how this is reflected in an individual patient. Such practice-related parameters are very much determined by the individual practitioner and her/his experience, intuition, and personal perception and interpretation of the situated encounter with the individual patient, based on practice experience.

The challenge involved in standardising knowledge in acupuncture is further complicated by the fact that the different acupuncture courses teach a number of styles (or traditions) of practice (ibid). Each tradition may offer a different interpretation of theory and practice that was developed by different influential 'charismatic' teachers. As demonstrated by Birch (1998), acupuncture is diverse in practice styles which significantly differ in their degree of holistic engagement. For example, the five elements style indicates probing into the patients 'constitution' and emotional makeup in order to establish the treatment strategy, while in Traditional Chinese Medicine (TCM) the practitioner is interested more in the physiological manifestation of symptoms and less in exploring the patient's body, mind and spirit interrelations. The stems and branches approach, taught at one of the leading schools in the UK, is taught according to a more esoteric approach to practice. The different practice styles impact on various aspects of practice, such as the selection of acu-points, the length or intensity of treatment, or the way that the patient-practitioner relationship is formed.

In homeopathy, similar difficulties are present. In their insightful exploration of demarcation and transformation of knowledge as a strategy of professionalisation in homeopathy, Cant and Sharma (1996a) discuss the importance of specialised knowledge in legitimising professional status as part of closure strategies. They explore the way that NMQ homeopaths are engaged in a professional struggle for recognition in the eyes of the medical profession, the government and the public. To acquire such legitimacy, they argue, both the content and practice of homeopathic knowledge needs to be accredited and validated. This however is complicated by the artistic nature of homeopathic knowledge. In particular what is difficult to standardise, is the process of homeopathic prescribing, by which the practitioner has to identify the one, most suitable remedy to the individual patient, out of thousands of remedies:

> The NMQ homeopaths especially stress that one can get only very approximate results through prescribing if this is done simply by looking up symptoms in the repertory[27]. Some will use terms like a 'feel' for the case, 'intuition', the 'art' of prescribing, etc. Obviously this knowledge is hard to codify and is gained largely by experience and through the observation of 'expert' practitioners at work (Cant & Sharma, 1996a, p. 581).

In her ethnographic study of homeopathy training, Gale describes how the homeopathic healing process involves the application of homeopathic remedies 'which stimulate the body's own vital force or self healing mechanism' (Gale, 2007, p. 212). Hence, students are required to learn in detail not only their patients, but also 'the personality' of each of the homeopathic remedies, and how each remedy, like people, represents a unique picture of mental, physical, emotional, social and spiritual aspects. The practice of finding how a certain remedy, out of thousands of remedies, corresponds best with the energy of a certain patient, requires the students to possess a degree of flexibility, uncertainty (ibid, p. 213), intuition and experience. In fact, there is no standard approach to homeopathic prescribing. Rather, there are numerous methods of homeopathic prescribing that are different from one another. Gale describes how the teaching

[27] The repertory is a book listing thousands of symptoms, and next to them potentially matching homeopathic remedies. The homeopath lists the patient's unique representation of symptoms, in search of the most suitable homeopathic remedy to match the 'totality of symptoms'.

of homeopathic remedies involves certain characteristics that cannot be fully grasped by language, and which are un-codified in nature:

> The discussion of cases in the classroom is very often within remedy lectures, which tends to reproduce 'ideal' cases. Narrative then is used as a teaching tool to illustrate the remedies, often to help students to get a feel for the 'energy' or 'essence' of a remedy. The meaning of 'essence' tends to lie somewhere in the emotional/social realm, and cannot be grasped by language. It may be the atmosphere in the room, such as in the case of Staphysagria class... (Gale, 2007, p. 214)

So far I have discussed the drive of NMQ acupuncturists and homeopaths to professionalise, and with it the recognition of the need to formalise education which involves the challenge of standardising indeterminate knowledge. In the next section I will discuss the entrance of a major player in this process, surprisingly under explored in the CAM context - higher education.

3.6 The entrance of higher education institutions (HEIs) to the CAM arena

Since 1995, universities in the UK have provided a platform for exploring exciting developments in CAM's organisation, professional maturity and increased status of several therapies. At the same time the entrance of CAM into the academia involved fierce arguments between CAM supporters and sceptics, as well as within CAM between different groups over the shaping and transmission of knowledge. At times this arena seemed to reflect an optimistic outlook at the future of CAM, while at other times it appeared as a site of conflict between the worst of enemies, filled with rejection and contempt. The inclusion of BSc CAM courses in university curricula, in particular homeopathy but also of acupuncture, was under concentrated criticism by several high-profile academics, attacking the therapies' lack of scientific basis and 'academic nature' (Giles, 2007; Corbyn, 2008). This attack, which argued against the teaching of CAM in HEI, was so bitter and sarcastic in nature that observers have to wonder what drove such an outburst of anti-CAM sentiment. Amongst the titles appearing in the popular media one would find language such as 'regulating quack medicine makes me feel sick', on 'The Times Online' (Colquhoun, 2008), or 'Shamed: Universities offering bogus

degrees in alternative medicine', in the Daily Mail (*The Daily Mail Online*, 2008). At the same time, from within acupuncture and homeopathy, debates emerged between practitioners and between different professional bodies over what some perceived as 'surrendering' autonomy over practice and over expert knowledge to mainstream institutions, which will result, many argue, in the loss of the holistic nature of practice.

UK universities came into the field of CAM education in 1995 (Isbell, 2004, p. 92). Prior to that, CAM education was delivered by private colleges and from the early 1990s also by further education institutes. The number of CAM courses grew dramatically from less than five in 1995 to 64 Higher Education accredited courses in 2009 (The Prince's Foundation for Integrated Care, 2009), of which 44 were at BSc, BA or MA level and the rest at foundation level. The courses were delivered across 47 institutions, including 21 universities, as well as university accredited courses taught by affiliated CAM colleges. Figures on enrolment to CAM courses in UK universities are available on UCAS (Universities and Colleges Admissions Service) and on HESA (Higher Education Statistics Agency) from the year 2002 onwards. The number of new students enrolling on CAM University courses grew from year to year, reaching 1,741 in 2008/9, until it dropped for the first time to 1,509 new entries in 2009/10. In 2002 there were 2,985 students enrolled on university CAM courses, including 564 new entries at stage one. This number more than doubled by 2007/8 reaching a total of 6,215 students, including 1,111 new entries. In 2008/9 the number of new students enrolling on CAM courses increased to 1,741, an increase of more than 300 percent in new enrolments in a space of six years. In the following two years a fall of about 12 percent in new enrolments on to CAM courses was noted.

Table 2: Number of students on CAM University courses 2002-2010, taken from HESA and UCAS

YEAR	**New entries of students on HEI CAM courses** (at undergraduate or foundation level)	**Overall number of HEI CAM students** (at undergraduate or foundation level)
2002/3	564	2,985
2007/8	1,111	6,215
2008/9	1741	6,865
2009/10	1509	7,340

While both acupuncture and homeopathy had plenty of engagement with University education, their courses did not have the same fortune. In 2003 there were four universities offering BSc (Hons) Acupuncture courses. This number grew to ten in 2009 but dropped to eight for the year 2011. In contrast, there were three homeopathy courses in three UK universities in 2003, and four in 2009. However, more recently only one BSc (Hons) Homeopathy course at the Centre for Homeopathic Education (validated by Middlesex University) was recruiting in 2011. It is difficult to speculate why homeopathy has not been as successful as acupuncture in its academic journey to date. Surveys suggest that homeopathy is as popular – if not more so – than acupuncture both in the UK and worldwide (Ong et al., 2005; Thomas & Coleman, 2004). Possibly it may have to do with the attacks on homeopathy from within academia over its 'unscientific nature' (for example Colquhoun, 2007), although, it should be said that these attacks were also aimed at acupuncture. In any case, the difficulty of recruiting new students in CAM courses was felt all across the board, including by acupuncture courses, with universities reporting 'slow' recruitment as the reason for closing CAM courses (Corbyn, 2009).

To provide a brief overview of my thesis so far, in Chapter Two I discussed the emerging holistic discourse that is central to CAM, in relation to the critique of biomedicine and as part of a medical counter-culture. I presented a number of

perspectives on this holistic discourse to demonstrate its multi-dimensional and dynamic nature, which is influenced by political and societal events and relationships, rather than, as a kind of 'essentialist', static discourse. In particular I drew on the 'holistic discussion' of Scott (1999) as a useful analytical framework, placing holism in CAM critically in relation to the critique of biomedicine's 'dualistic logic'. I discussed the various holistic concepts that are expressed in the literature in relation to CAM and I placed them in the context of 'wider self' and 'wider world' holism. I then discussed literature which examined potential tensions and potential limitations to CAM's holistic discourse, including suggestions that the focus on individuals and on wider self holism corresponds with a lack of awareness of the broad environments of patients (wider world). In the present chapter I moved on to examine the holistic discourse in CAM, in the context of professionalisation and the process of the formalising acupuncture and homeopathy education. Drawing on professional closure strategies and the discussion of the unique nature of expert knowledge in CAM, I discussed hoe the tensions and conflicts that are part of formalising education are linked with the 'holistic expression' that is inherent in acupuncture and homeopathy. This leads me to the question of how the holistic discourse as an expression of the therapies' esoteric knowledge and which contributes to the therapies' high 'I/T ratio' - is negotiated, and influenced, by the process of formalising education. In the empirical chapters (Chapters Five, Six and Seven) I will examine the nature and the expression of the holistic discourse of NMQ acupuncturist and homeopath in the UK, and their degree of reflectivity in relation to this discourse, as an essential professional competence. I will consider the strategies that are used by practitioners in negotiating the tensions that are part of formalising education, including the professional dilemma between increasing professionalisation while maintaining the unique nature of their expert knowledge. But before discussing the empirical data that are at the centre of this thesis, the next chapter presents the methodological framework and ethical perspectives that guided them.

Chapter 4

Methodology

In this chapter I discuss the methodological framework that is used to support the overall aim of the research. The chapter begins with a discussion of the qualitative methodology employed in this investigation. This is followed by a review of the sampling approach taken. The process of in-depth interviewing is described, as well as the interviewees' profile. The various stages of the method employed of qualitative content analysis are explained, followed by a description of the method of participant observation which took place during professional training and practice. Then, the manner in which online documents of practitioners, schools and professional bodies were considered is discussed and presented. Finally, the study's' ethical considerations are examined, including confidentiality, informed consent and the position of the researcher as an 'insider/outsider' in relation to the investigation.

The overarching aim of this research is to explore the way that NMQ acupuncturists and homeopaths in England, as part of their efforts to professionalise and formalise their educational structure, negotiate holistic concepts that are embedded in their theory, practice and discourses.

In order to answer the research question I conducted an in-depth, qualitative inquiry using several data sets, including:

(1) Twenty five in-depth interviews with practitioners of acupuncture and homeopathy in London and the South of England, including practitioners who are also school principals and/or lecturers.

(2) Participant observation of teaching during the academic year 2007/8 on an undergraduate course entitled BSc (Hons) Acupuncture delivered at one British school for Chinese medicine. The participant observation included supervision of

six final year students on a research methods[28] unit; the assessment of 22 student dissertations; and the observation of two cohorts of students' oral presentations (24 presentations in all) of their final year research project.

(3) A review of documents of several sources of data: the study participants' professional websites; course information of 14 acupuncture and 13 homeopathy schools who are accredited by the British Acupuncture Council or the Society of Homeopaths; and finally, the BAcC and SoH education and accreditation documents, including course accreditation guidelines and educational policies.

(4) Two non-participant observations of practice which included three acupuncture treatments within the same acupuncture practice and one homeopathy consultation in a homeopathy practice.

4.1 Utilising an in-depth qualitative methodology

To address the research aim I adopted an in-depth qualitative research approach. This enabled me to take the participants' worldview as a standpoint, whilst using theoretical perspectives to study the meanings these particular individuals and groups attributed to social experiences (Creswell, 2007, p. 37). This approach advocates the study of people inductively 'from the ground up', in their natural settings, starting from the patterns and themes generated from the original data collected towards generalisation, and hypotheses.

Qualitative research allows the emergence of original data by exploring the practitioners' point of view (Pope & May, 1995, p. 45), through data collection methods such as interviews and observations. It is, therefore, a suitable research approach to meet the aim of this research. By using an in-depth qualitative approach, I brought practitioners' perspectives to the forefront, narrowing the gap between the empirical data and my conceptualisation of it. By doing so, I aimed to

[28] The original title of the unit was 'Enquiry Skills'

move away from what Gubrium and Holstein (2002, p. 12 Hoffman, 2007) described as the 'basic' interviewing model whereby 'the subject is not an agent engaged in the production of knowledge' and where the job of the researcher is to extract data from the interviewee 'without the interviewee contaminating the data with subjectivity' (Hoffman, 2007, p. 319). Rather, I used an 'active' model in which the interviewee is playing a more active role in shaping the data. This is in line with Gubrium and Holstein's commentary on the interview process:

> As the interview has become democratized, we no longer look to experts to learn about social phenomena but go directly to those experiencing the social phenomena themselves. Researchers are more committed to allowing the people involved to speak for themselves in their own way (Gubrium & Holstein, cited in Hoffmann, 2007, p. 319).

It is important to consider the field of research and the players involved in the investigation, i.e. practitioners, their schools, their professional bodies, their consumers, the media, higher education, the medical profession, and the government, as a *dynamic* sociological field rather than as *static* and *essentialised* one. Acupuncture and homeopathy practice, education and professional strategies are constantly changing by both internal and external processes. It was therefore important to adopt an iterative and developing research strategy that allowed observation and reflection on changes on the field that is being studied.

4.2 Sampling for interviews

In order to discuss the sampling approach in this study it is first important to briefly consider the concepts 'generalisability' and 'transferability' in the context of qualitative research. Generalisation involves reasoning through drawing broad conclusions from particular cases, 'that is, making an inference about the unobserved based on the observed' (Polit & Beck, 2010, p.1451). In most cases the role of qualitative research is not to generalise in the same way that quantitative research aspires to, but 'to provide a rich, contextualized understanding of some aspects of human experience through the intensive study of particular cases' (ibid, p.1451). Some researchers argue that the aim of

qualitative research is to ensure that findings are transferable by the in-depth study of particular cases, and that generalisation is always problematic due to the unique context of any findings. 'Transferability' refers to the degree to which the findings from qualitative research can be transferred to other contexts or settings and it involves using findings from one inquiry to a different group of people or setting (Polit & Beck, 2010). Mason (1996, p.6) suggest that qualitative research should provide explanations that are in some way generalisable and which should resonate more widely - beyond the particular case. Moreover, it is suggested that in-depth qualitative research offers an opportunity for revealing concepts and theories that are not unique to a particular setting, as the rich and detailed nature of the findings makes them especially more insightful in relation to other settings (Polit & Beck, 2010). In order to enhance the generalised inferences of findings it is important that the study sample aspires to consist of participants who best represent, or have knowledge of, the research topic. This ensures efficient and effective *saturation* of categories, which means that sufficient data to account for all aspects of the studied issue have been obtained (Morse, Barrett, Mayan, Olson & Spiers, 2002). I shall return to discuss the generalisibility of my research study, both in terms of the methodology that I used, and in relation to specific findings, in the concluding chapter of the thesis. For now, I would like to describe the choice of cases in this study and the sampling approach.

Qualitative sampling was achieved after careful considerations of constraints of time needed to gather data and limitations of availability or accessibility of the studied population (Procter & Allan, 2006, p. 173). Moreover, sampling was carefully considered during several stages of the research process. First when collecting the data, then when analysing the data, and finally when presenting the data (Flick, 2006, p. 122). Generally, in qualitative research, the starting point is the purpose for which the sample is required (rather than the sample size), which then guides the number of participants that are recruited (Parahoo, 2006, p. 277). In a broad sense sampling in qualitative research can be described as 'selective' in that it involves subjective judgement of the researcher in the selection process and the selection criteria (ibid, p. 273). The sampling method I used in this research is best described as an integration of 'purposive' and 'theoretical' sampling. Both terms are quite often used interchangeably (Silverman, 2011, p.

389) and there is a need to define the differences between the two approaches. The selection according to purposive sampling refers to the selection of accessible and consenting participants who are best placed to contribute towards an understanding of the research concerns (Parahoo, 2006, p. 274). The essential feature of theoretical sampling is that the researcher does not know in advance, the kind of participants that will be included. Rather, as emerging data are analysed, the emerging themes and ideas guide the researcher in choosing participants that are best placed to inform the research (ibid). The decision to stop collecting data was taken at the point of saturation of data and themes under the research questions and their related categories that were presented as part of the process of qualitative content analysis, a process which will be described in details in this chapter. Such saturation enhances the likelihood that analytic generalisation can occur in relation to the study findings (Polit & Beck, 2010). In the following two sections I will further consider the sampling approach in this study.

Purposive sampling

As discussed in the previous section, purposive sampling is applied to situations in which the researcher is aware of certain participants' characteristics and experiences that are seen as likely to produce useful data, these qualities being relevant to the topic under investigation. Such an approach allows for concentration on the research question at hand and focuses on the wealth and depth of relevant data (Denscombe, 2007, p. 17). Several criteria pointed at the need to employ purposive sampling as part of the data collection stage:

a) Current practitioners: In order to ensure that participants were aware of current developments in their practice environment, all my interviewees were active practitioners of acupuncture or homeopathy in England. This however, is not a straight forward task and it represents a number of challenges, in particular since the majority of CAM is practiced in the private market (Thomas & Coleman, 2004). First, different practitioners were trained during different times along the 'professionalisation continuum' of NMQ acupuncture and homeopathy and are not

necessarily attuned to the same political and historical developments within their profession. The fact that many work in their private practice, without necessarily interacting with other practitioners, might potentially lead to certain isolation from developments in practice. Moreover, as argued by Scott (1998), it is not in private practitioners' economic advantage to locate their treatments in factors outside the patient's immediate control. Also, as pointed out by Cant (2009), the location of CAM practitioners in middle-class areas with middle-class demographic features suggests important spatial differences and geographical inequalities in both provision and utilisation of CAM. These factors may place practitioners in a position of limited awareness to matters of wider world holism. Therefore practitioners might develop a holistic discourse or 'holistic perspective' that is different to that of practitioners who work also within NHS settings and who interact with other practitioners in multi-disciplinary clinics. In reference to this, it is important to note that that the majority of the acupuncturists and half of the homeopaths participating in the study were engaged in some kind of multi-disciplinary activity. This is either through educational activities, working in NHS facilities, or working in an inter-disciplinary clinic. This, I believe, somewhat reduces the problem of practicing in isolation.

Moreover, it seems that of the two practitioner groups, homeopaths were more suspicious and less forthcoming when it came to taking part in the study. At a certain point during the recruitment process, I found myself with an uneven number of acupuncture/homeopathy practitioners, with significantly less homeopaths interviewees. This required extending my effort to recruit homeopaths and engage in phone conversations with practitioners to ensure them that my view of CAM and of homeopathy practice is sympathetic. One educationalist homeopath arranged to meet me but cancelled the interview on two different occasions. Another homeopath spoke with me three times over the phone until eventually she felt confident enough to be interviewed. This hesitation to participate in the research may be a result of the intense attacks on homeopathy which I discussed previously in the thesis. It is also possible that the presence of a nearby CAM research group created certain 'saturation' in research with CAM practitioners in the area, although I had no indication that this was the case.

b) Diverse practice setting: Considering that acupuncture and homeopathy are mostly practiced in the private sector, in both rural and urban settings, it was important to include practitioners who work in both kinds of settings. Demographically, some practitioners work in affluent areas, and have little engagement with patients from lower socioeconomic backgrounds, while others work with a more culturally and socioeconomically diverse population. In terms of the practice setup, as I mentioned previously, some practitioners work in isolation, while others work alongside other practitioners (CAM and non-CAM), or inside an NHS setting[29]. By taking the aforementioned characteristics into consideration, I aimed to ensure that different practice settings were represented in the research.

c) Membership in a professional body that is engaged with professionalisation: Both acupuncture and homeopathy are engaged in professional projects; this is a central theme of this research. In order to consider the way practitioners negotiate holism and the formalisation of their education, it was important to ensure that participants are members of the leading professional bodies of acupuncture and homeopathy. The literature identified the British Acupuncture Council (BAcC) and the Society of Homeopaths (SoH) as the professional bodies leading the therapies' professional projects. Relying on the two largest NMQ professional bodies, especially in the case of homeopathy, implies that not all voices of NMQ practitioners were represented. As discussed in the previous chapter (Clarke et al., 2004: Cant 1996) the formalisation of education that (in the case of acupuncture and homeopathy) is lead by SoH and BAcC is not free of criticism and debate, and it is possible that more critical voices may be heard from associations outside these two professional bodies. Nevertheless, since the impact of formalising education is central to this study, I chose the two leading professional bodies, who are engaged in that process.

d) Comparing holistic views of non-medically qualified and medically qualified practitioners: Initially, I was hoping to compare the holistic discourse of NMQ practitioners with those of medical acupuncturists and homeopaths. Indeed, NHS ethical approval was granted to permit such interviews. However, as the study progressed it was evident that it was difficult to recruit such practitioners. First,

[29] Working inside an NHS surgery does not necessarily involve direct contact with the GPs in that surgery. One of my participants sees patients in a GP's surgery but has very little communication with the owners of the practice.

when searching for medically qualified acupuncture and homeopathy practitioners within 20 miles of the University, only a small number of medically trained practitioners were registered. Second, only a small number of this practice group responded to my request to take part in this study, out of which only three set out time to meet me. At the time, due to personal matters, I had to postpone two of the meetings, and I was unable to reorganise these meetings later on. Since, at that point, I had already conducted interviews with four members of the Acupuncture Association of Chartered Physiotherapists (AACP), and since these interviews provided an insightful comparative angle to my research, I decided to include these data in the thesis. Physiotherapists have historically (Nicholls & Cheek, 2006) adopted a biomechanical model to legitimate practice that generally involves physical human contact, and which generally relies on manual therapy. They are increasingly integrating acupuncture into their NHS practice. Kelner et al. (2004) discussed the response of established healthcare, including physiotherapy, to professionalisation of CAM in Ontario, Canada. Using Alford's typology (Alford, 1975), they described CAM's position as part of a 'repressed' community population, while allied professionals, such as physiotherapy, are described as sitting both within the dominant professional group as well as part of the repressed group. This position and the holistic views of physiotherapists who practice acupuncture, is intriguing. While CAM practitioners are looking to move closer to mainstream medical care, which impacts on their holistic discourse, AACP practitioners might be looking to increase their scope of practice and perhaps their professional autonomy by adopting acupuncture practice and integrating it into their therapeutic arsenal. Here, it is interesting to consider how holism is negotiated by moving somewhat in an opposite direction, perhaps to increase the 'holistic expression' of practice in the process and use holism as a 'negotiation tool' between physiotherapists and the medical establishment, and between physiotherapists and their clients . This is in contrast to tempering holistic claims or the increased infusion of biomedical knowledge into the holistic narrative, as discussed in relation to professional strategies in CAM (Cant, 1996; Welsh et al, 2004).

e) Distance/geographical location: As discussed in the introduction, practitioners of acupuncture and homeopathy mainly work in private practices that are geographically distant from one another. Yet, face to face interviewing involves

great deal of travelling and time commitment. Hence, there was a need to restrict the geographical area in which practitioners were approached. Practitioners were therefore invited to take part in the study if they resided in the South of England.

Theoretical sampling

One of the strengths of qualitative research is its flexible nature which allows maintaining a theoretically informed sampling approach as the research develops (Silverman, 2006, p. 391). In particular, Silverman points out, such flexibility and the use of theoretical sampling as the research develops is appropriate when, as new factors emerge, the researcher wishes to increase the sample to learn more about these emerging factors, to confirm or refute the emerging explanations, in particular in relation to the conceptual and theoretical aspects of the research (Procter & Allan, 2006, pp. 182). Here, participants are selected 'according to their (expected) level of new insights for the developing theory in relation to the state of theory elaboration so far' (Flick, 2006, p. 126), and according to the uniqueness/ relevance of cases rather than their representativeness.

Since in this thesis I discuss the holistic discourse and the formalisation of education of NMQ acupuncturists and homeopaths, and the organisation knowledge in that process, it was important to increase the input from those who drive the process forward, including school principal and educationalists. As the research study developed, it was made clear to me that, while the emerging data from the first 15 interviews shed light on the nature of the holistic discourse of NMQ acupuncturists and homeopaths, there was a need to increase the focus of the investigation on the way that this discourse is negotiated during the process of formalising education. What was missing was increased input from educationalists who could reflect on the relationships between acupuncture and homeopathy courses accreditation and HE validation, and its impact on a) the development of reflectivity in relation to the holistic discourse, and b) the conflicts that are part of standardising esoteric knowledge. I therefore approached school principals and acupuncture and homeopathy educationalists to increase the pool of data in

relation to these concerns. Table 3 (below) provides a summary of the sampling approach:

Table 3: Sampling decisions in the research process

Stage in research	**Sampling method**
Data collection	Purposive sampling, and, at a later stage, theoretical sampling.
Data analysis	Theoretical and inductive analysis: Identifying the sections in the interview where the interviewee makes reference to pre-explored concerns (literature review) and conceptual threads in the context of the research questions.
Presentation of data	Theoretical and inductive: Presenting findings from the analysed data based on pre-explored concerns (literature review) and conceptual threads in the context of the research questions.

4.3 Data collection

In the following section I will discuss each of the data collection approaches in this research.

In-depth interviews

In-depth interviews have been described as semi-structured or unstructured interviews that are focused on attaining rich and detailed accounts of the participants' perspectives, understandings and knowledge of the research topic,

as well as their feelings towards it (Yates, 2004, p. 156). The use of open-ended and flexible questions as well as probing responses was considered to be able to provide better insight into my interviewees' views, opinions, experiences, and interpretations (Byrne, 2004, p. 182). The choice of in-depth interview was motivated by my desire to be attuned to what the participant could share with me regarding the research topic and, to a certain extent, to be able to represent the interviewees' own language and bring their own voices to the fore (Byrne, 2004, p. 182).

Recruitment

Participants were identified via either the NMQ acupuncture or homeopathy practitioners' on-line database. I approached participants via an email which included an invitation to take part in the study, as well as an information sheet describing the study; its objectives; and the interview procedure; ethical considerations including confidentiality and informed consent; and contact details (Appendix 1). Practitioners who agreed to take part in the study received an electronic copy of the consent form requesting them to confirm that they had read the information sheet (Appendix 2). This consent form also called for the research participants to give permission to be audio-taped and their interview data transcribed. In addition, participants were assured via this consent form that they are free to withdraw from the interview at any time. All interviews were tape-recorded and transcribed. Interview-length varied from 45 minutes to two hours, depending on the time available for the interview and on the depth of the information that the interviewee chose to share.

Most interviews took place either in the interviewee's private practice or at their home, although several participants chose to be interviewed at the university in one of the interview rooms in my department. The majority of interviews took place over a period of two years between September 2007 and September 2009. Three interviews were added in August 2010. With four of the study participants, I conducted a second interview to follow up on some of the issues that were discussed during the first interview; therefore, in total, I conducted 29 interviews

with 25 participants. Each interview was audio-recorded and once the interview was transcribed (verbatim), an electronic copy of the transcript was sent back to the participant, inviting comments, changes including deletions and additions, should they wanted to do so. This allowed participants another opportunity to reflect on the topics raised during the interview.

The interview format

Certain factors influenced the interview format, including the research interest (aim, objectives) and what interviewees felt was relevant in the context of the broad topic presented to them. At times the interview was influenced simply by 'external' factors such as time constrains which made the interview more rushed in nature. For example, one interview with a homeopathic school principal lasted for more than two hours; the interviewee needed no prompting, and if it was not for the fact that I had to leave, the interview would have been even longer. In contrast, another interview was only 45 minutes long due to strict time constraints, and although the interviewee had a lot to say, there was a need to pose more direct and concise questions in order to make sure that certain aspects of the research were discussed. This compromised the flow of the interview and resulted in a less rich transcript than in most interviews. In most cases interviews took a conversation-like format and I invited practitioners to describe their experiences and express their views with little interference on my behalf. Often, as a starting point, I asked participants to describe their practice-biography and consider challenges they experienced in practice. I would often ask practitioners to describe several patients to learn about their approach to practice and what they perceive as 'key ingredients' to practice, as well as how they describe their therapeutic approach and communicate it to their patients.

The emerging data would often be linked, when possible, to questions about the practitioners' websites and the way their practice was presented and described online. This 'rich' description provided insights into the way practitioners negotiated their practice in the current setting in which they operated, and the sorts of challenges they faced, as well as their perception and description of

holistic claims, holistic concepts and holistic rhetoric used. For example, the following question was presented by reading the interviewee a paragraph from an acupuncture school website:

> Could you please elaborate on the meaning of the following paragraph in the context of the college philosophy: 'Oriental medicine is holistic, and so is everything we do – the idea that the mind, body and spirit cannot be separated is fundamental and, as a student, you are encouraged to develop a holistic lifestyle'?

If participants held a key position alongside their practice, for example principals of acupuncture or homeopathy schools, I would ask them to describe the development of the school and the way the process of professional accreditation, or university validation of their course was negotiated. For example:

> Could you reflect on the development of your [homeopathy] school from when it was established up to today and describe the main challenges involved in bringing it to what it is today?'
>
> Could you describe the process of university validation of your school and the main challenges involved in this process?'

This approach to interviewing provided a useful tool to ensure that although the interviewee was considered the expert and was encouraged to provide her/his perspective including descriptions of what she or he perceived as important, I was able to actively engage the in development of rich data and of contextual meaning (Legard, Keegan & Ward, 2003, p. 139).

Participants in interviews

I approached approximately 250 practitioners who were on the BAcC and SoH register, and who resided in a defined geographical area[30] In the South of England, out of which 21 practitioners agreed to be interviewed. As discussed in

[30] I approached all BAcC and SoH practitioners residing between Chichester to the East, Ringwood to the West, and Basingstoke to the North, which is mostly in Hampshire and West Sussex.

section 4.2, I also included a small sample of four more practitioners, members of the AACP. The table below provides a summary of participants' characteristics:

Table 4: Participant characteristics – in depth interviews (homeopathy)

Pseudonym	CAM practice	Years in practice	Private or NHS	Other professional roles
Sally	Homeopathy (classical and combinations homeopathy)	8	NHS	NHS nurse, Head of Complementary Therapies in an NHS hospital, lecturer in a homeopathic school
Mick	Homeopathy (classical)	22	Private	Member of the Board of the Society of Homeopaths
Phil	Homeopathy (classical and combinations homeopathy)	1	Private	Paramedic
Penny	Homeopathy (classical)	20	Private	Principle of a school for homeopathy; member of the Society of Homeopaths education department
Andy	Homeopathic vet (classical and medical) & acupuncture	14	Private	Vet
Louise	Homeopathy (classical)	10	Private	
Martyn	Homeopathy (classical, combinations, complex homeopathy), cranio-sacral therapy	14	Private	Co-owner of a centre for natural medicine
Chris	Homeopathy (classical) & acupuncture (TCM & Five Elements)	10	Private as well as in NHS facility	
Amy	Homeopathy (classical)	12	Private	
Helen	Homeopathy (classical), nutritional therapy	27	Private	
Ruth	Homeopathy (classical)	7	Private	

Table 5: Participant characteristics – in depth interviews (acupuncture)

Pseudonym	CAM practice	Years in practice	Private or NHS	Other professional roles
Nicola	Acupuncture (Stems & Branches)	30	Private	Principle of a school of Chinese medicine
Marilyn	Acupuncture (Five Elements; Stems & Branches)	10	Private	Trained as an MD; Senior Lecturer in a school of Chinese medicine
Lisa	Acupuncture (Five Elements)	25	Private	Principle of a school of Chinese medicine
Jeannette	Acupuncture (TCM & Five Elements)	34	Private	Principle of a school of Chinese medicine
Sue	Main: Acupuncture (Five Elements); other: Alexander technique; Clinical Nutrition (MSc); homeopathy	3 (acu.) and 10 (hom.)	Private	Nursing; lecturer in a school for Chinese medicine
Tara	Acupuncture (TCM & Five Elements)	2	Private	
Ann	Acupuncture (TCM & Five Elements); reflexology	3	Private	Nursing
Alan	Acupuncture (TCM & Five Elements)	7		
John	Acupuncture (Five Elements)	23	Private	Senior lecturer in a university based acupuncture course; involved with coordination of acupuncture research
Lucy	Acupuncture (TCM & Five Elements)	1	Private	PhD, principal lecturer and researcher in biomedical sciences at a university
Matt	Acupuncture (medical)	3	NHS	Physiotherapy
Shelley	Acupuncture (medical)	6	NHS	Physiotherapy
Carol	Acupuncture (medical)	2	NHS	Physiotherapy
Lauren	Acupuncture (medical)	6	NHS	Physiotherapy

There were 25 practitioners interviewed, of which 17 were female and eight males. Participants came from varying demographic settings, practice experience, levels of education and styles of practice. Participants had been in practice between 1 to 34 years. Fourteen practitioners practiced acupuncture, eight practiced acupuncture, and three practiced both acupuncture and homeopathy. Apart from the four physiotherapists, all participants practiced the non-medical form of acupuncture/homeopathy practice. Ten of the participants had additional health related professional qualification, including physiotherapists (4), nursing (3), conventional medicine (1), veterinary (1) and paramedic (1). Amongst the participants there were nine educationalists, including four school principals and five lecturers.

4.4 Interviews' data analysis: Qualitative content analysis

In the following section I will justify the approach to data analysis of the interview data, namely that of qualitative content analysis. I will outline its step by step approach that was used to reduce and analyse the data in the context of the research questions. Qualitative content analysis is a commonly used procedure for analysing textual materials from various sources, including interview data (Bauer, 2000, cited in Flick, 2006, p. 312). The goal in qualitative content analysis is to systematically reduce the data at hand to the point that the remaining data is relevant in the context of the research questions. An essential feature of this method is the use of key categories which often *derive from theoretical models.* Unlike several other qualitative data analysis approaches, categories are brought to the empirical material and are not necessarily developed from it, although the categories are repeatedly assessed against the data and are modified if necessary (Flick, 2006, p. 312). Hence, rather than starting the research with a (deductive) hypothesis that is to be proven or disproven, the method of QCA identifies certain key categories from available literature and theoretical models and then turns to the data to consider how these categories or terms are manifested in the data.

This method was first developed approximately 30 years ago by Ulich, Hausser, Mayring et al. (1985, cited in Mayring, 2000) in order to analyse a very large data set from interviews during a longitudinal study about psychosocial consequences of unemployment. The method was initially developed as a quantitative approach to analysing textual data, but was later adapted by Mayring as a qualitative approach (Ritsert, 1972, cited in Kohlbacher, 2006). Mayring (2000) offers a structured procedure for QCA. The main idea of the process is to formulate a criterion of definition, deriving from a theoretical background and the research questions, which determines which textual material is taken into account. The following flow chart provides the basic procedure of the method from the initial theory to the final analysis and interpretation:

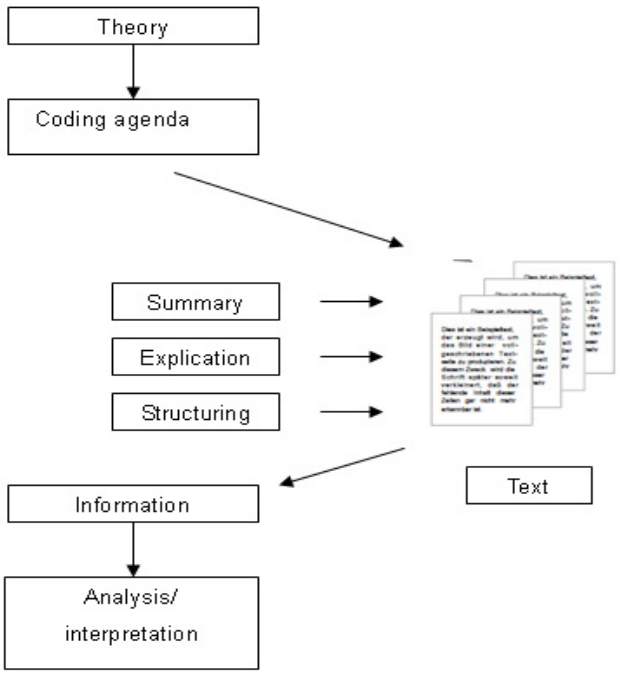


Figure 6: the basic procedure of Mayring's qualitative content analysis (Kohlbacher, 2006)

Theory basis for coding agenda (steps one and two)

In this research the coding agenda derives from the literature discussing several theoretical threads and the way they are conceptualised alongside one another: holistic concepts in CAM's rhetoric; potential tensions inherent in these holistic claims; the formalisation of educational structures as part of the therapies' professional project and the challenge that is part of the therapies I/T ratio in relation to the standardisation of expert knowledge.

Analytical procedures (step three)

This model, which was developed by Mayring, (Flick, 2006, pp. 312-315; Kohlbacher, 2006), involves three distinct analytical procedures of the textual research materials:

1. Summary: In relation to the research questions and in the context of the theoretical/conceptual framework of the research, the researcher goes through the data and attempts to reduce the material while preserving the essential content, and by abstraction, creating a manageable corpus which still reflects the original material. According to Mayring (1983, cited in Flick, 2006, p. 313), it is important that in this process:

a) The research question is defined in advance

b) The research question is linked theoretically to earlier research on the issue being investigated

c) The research question is differentiated to sub-questions

2. Explication: This stage involves clarifying and annotating the data. Categories are defined on the basis of the research question and the theoretical framework, and the text that remains after the first step is placed under each category.

The explication stage involves arranging the text in two columns:

- A coding unit (for example: conceptualisation of holism)

- A contextual unit, which corresponds with the conceptual threads of the research, further breaks down the data that was gathered under the coding unit (for example: ‘reference to wider world holism in the context of the broad environment’).

3. Structuring: The goal of this stage is to filter out a particular thematic structure which derives from the material. A third column is added, which is a further analysis and breakdown of the contextual units into smaller, ‘analytical units’. Let me provide an example for the procedure at this stage:

For example, a section of the text corresponds with the category *‘holism as treating the constitution of patients and not only symptoms in isolation’.*

The text that corresponds with this category is first broken down systematically to ‘analytical units’, for example:

> [participant] says that considering the constitution of patients requires consideration of the inter-relations between body, mind, and spirit’; ‘[participant] says that treating the patients’ constitutions requires extracting intimate and emotionally-charged data from the patient’; ‘[participant] says that some of her patients are not comfortable sharing very intimate details about their lives’ etc.

At this point the analytical units are re-examined against the contextual units in order to identify the meaning and relationships between the analytical units and ‘the broad story that is being told’ in the examined text. Subsequently, key examples and the findings are considered with respect to the research questions.

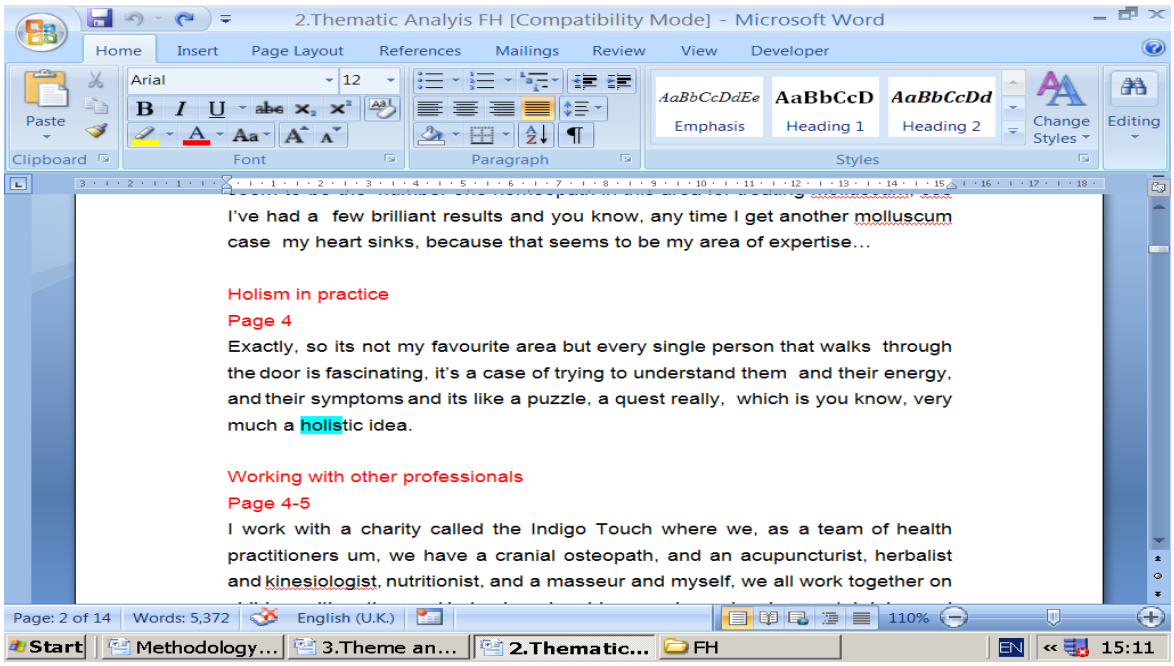
I will now move on to describe how I applied the method of qualitative content analysis in my research.

Stages of qualitative content analysis in my research

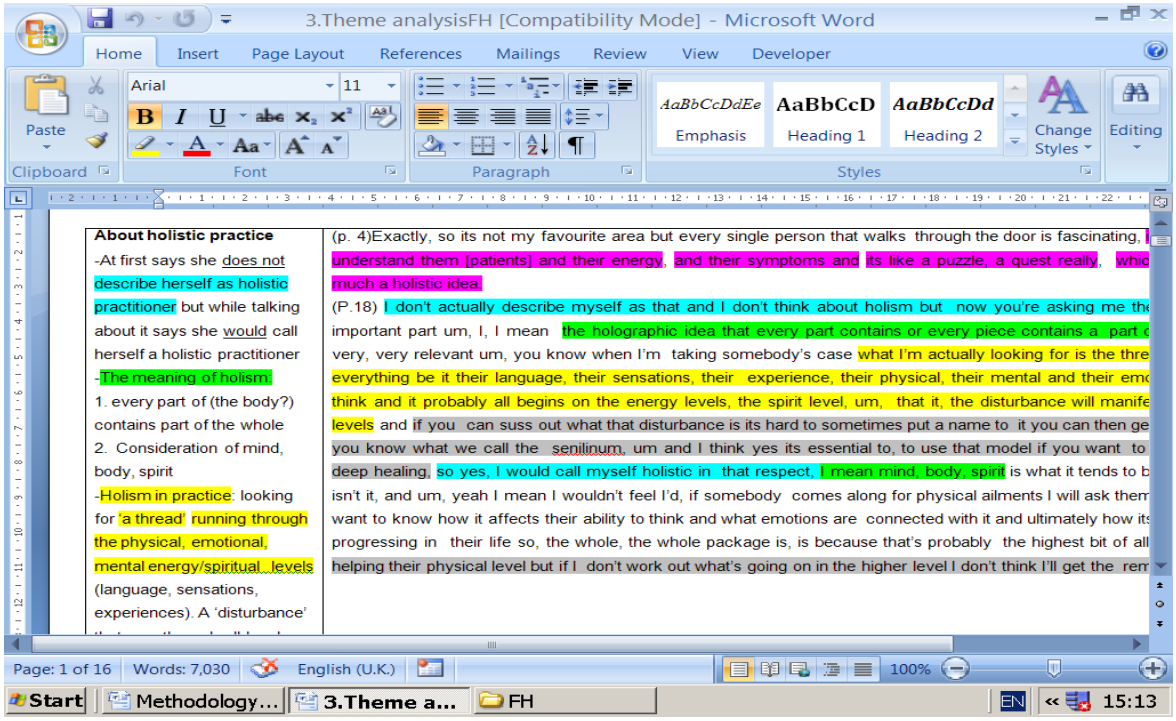
In this section I will describe and demonstrate how I used the method with the data I gathered during the interviews.

First step: At this stage I examined the data in relation to the research questions. I read through the interview transcript to familiarise myself with the text while making initial comments. When reading through the text the second time, I removed those sections in the text that were clearly not relevant to my research questions. For example, one practitioner discussed in detail his experience as a sales representative of a furniture company prior to becoming a homeopath. This part of the interview does not correspond with the research questions and so was removed.

Second step: This stage involved the mapping of the text and the introduction of broad categories (contextual units) against which the data was examined. The broad categories are developed in relation to the theoretical and conceptual threads of the research. During this step, I read the text that remained, and I selected and 'lifted' the parts in the text that related to each contextual unit, placing them under the corresponding contextual unit. The screenshot below is an example:



Once the data were clustered under contextual categories, I placed them in a separate column next to the corresponding category. At this point, as can be seen in the screenshot below, I systematically examined the data and I looked at the smaller, analytical units making up the text. As can be seen, I placed the analytical units under the broader contextual unit, and I assigned a different colour to each contextual unit. This allowed me to colour the corresponding text with a matching colour, and be able to identify quotes to support my analysis later on.



Third step: I refer to this step, defined as 'structuring' by Mayring, as 'understanding the internal story' being told by the interviewees. Once the data was clustered next to the corresponding contextual categories, and once it was further broken down into analytical categories, the next step was to consider the relationships between categories, and the story that they tell altogether in relation to the contextual categories. In practice, as can be seen in the example below, which is taken from one interview analysis, I first placed all analytical categories under their corresponding contextual category. I then considered the meanings of the categories when brought together.

The following example is part of the analysis of the text from Penny's interview. During the interview, Penny, who is a principal of a school for homeopathy and who is part of the SoH education department, discussed the formalisation of homeopathy education and the involvement of HEI in homeopathy education.

Penny's interview:

About formalisation of homeopathy education:

- Higher Education and universities play an important role in applying a yardstick to homeopathy training programmes

- Homeopathy training as led by SoH is trying to provide a yardstick/standards to training programmes in the UK

- There is a need to learn from the criticism of homeopathy ['elitist'; 'poorly researched'; 'low level of training courses'] and respond to it in a constructive way

- Having on board academics who are committed to the SoH guidelines [and to academic teaching guidelines] helps drive the process forward

- Newly developed university-based homeopathy courses impacted upon the number of students on existing homeopathy courses

- 'External' to the homeopathy training circle is a 'smear campaign' against homeopathy that impacts negatively on the popularity of courses

- The unique nature of the school (small and intimate, steady, devoted core group of lecturers,) and the fact that it is not a university/degree-based course

The next example demonstrates how the emerging analytical categories, and the data that they correspond with, are examined in the context of the research questions. In this example, contextual categories from Penny's interview, and the relationship between them, are considered in relation to the way that NMQ homeopaths negotiate the holistic premise of their practice in the course of formalising their educational structures, and the influence of HEI (Higher Education Institutions) on this process:

Penny's interview: The role of professional regulation formalisation of homeopathy training in addressing criticism of homeopathy

- Homeopathy is often criticised for having poor standards of research; poor standards in training courses and education; and that it is an 'elitist' discipline that is practiced by- and for- the upper-middle class in the UK. At the moment homeopathy is still seen at 'craft' level; a dilettante upper-middle class practice, rather than a 'real' profession.

(continues)

- There is a need to learn from and address the criticism of homeopathy instead of shying away from it. Instead, addressing such criticism should provide practitioners with the confidence they often lack when facing the nasty 'smear campaign' against homeopathy practice.

- Penny, with her personal 'baggage' from working in FE and HE, supports applying academic standards and 'yardstick' to training programmes. She also supports clear professional definition and organisation of homeopathy.

- Currently there is a big variety in the way homeopathy is being practiced and there is a need to define what homeopathy practice is and what homeopathy practice is not, for the sake of clarity for the public, policy makers and researchers.

- Hence, homeopathy should be organised under one regulating body that is democratically elected and structured, providing standard guidelines to training and practice.

- This will allow current criticism of homeopathy to be addressed and the establishment of clear criteria and benchmark.

- Therefore Penny supports unifying practitioners under the largest professional body which is the Society of Homeopath.

- Penny steers her college in that direction and strongly supports [and this is well embedded in the college 2009 prospectus] academic standards and research as part of the homeopathy curriculum. She suggests that the universities provided the welcomed 'push' and guidance in this direction.

Fourth step: Once I reached a clearer understanding of the text in relation to a category, I chose examples from the text which best represented and captured this understanding. Such examples were used to illustrate how the category was articulated by the participants, bringing the reader back to the actual data from which this conclusion derived.

Addressing the limitation of the method of QCA

Flick argues that 'owing to the schematic elaboration of the proceedings, qualitative content analysis seems clearer, less ambiguous, and easier to handle than several other methods of data analysis' (2006, p. 315). However, although Mayring himself suggests that this method should be used with some flexibility depending on the research question and the material at hand, there are several potential limitations to the procedure. There is a danger that the systematic nature of the analysis may obscure the depth of the text and the observation of potential underlying meanings. Also, the danger is that by working systematically through the data, the researcher may lose sight of the actual story being told by the interviewee. I have tried to avoid this potential pitfall in the following ways:

a) To avoid losing sight of the main story being told by my interviewees, and in order to maintain a representation of the original narrative, when presenting quotes, I refrained from breaking down the interview data into very small 'chunks'.

b) By triangulating data from several resources, including practitioners' websites, schools, professional bodies' documents, and participant observation, I was able to contextualise participants' narratives and experiences in the broader research field.

Having discussed in detail the in-depth interview as a main data collection tool, and the way interview data was analysed, I will move on to consider other data-collection methods that I employed in the course of the research.

4.5 Participant observation of teaching at BSc (Hons) Acupuncture in a BAcC accredited, university validated, school for Chinese medicine

Participant observation is a term that is often used in relation to ethnographic research (Walsh, 2004, p. 226). It usually involves fairly lengthy contact of the researcher in relevant settings, and multiple data collection including open-ended interviews designed to understand peoples' perspectives. It is sometimes complemented by the study of various sorts of documents, official, publicly available or personal (Hammersley, 2006 cited in British Educational Research Association, 2009). Observation and participant observation were developed to allow investigation of phenomena in their natural settings and are of particular value when trying to understand behaviours and interactions in a 'real world' context (Ritchie, 2003, p. 34). The distinction between 'observation' and 'participant observation' is not that easy to define and it has been argued (Hammersley & Atkinson, 1983, cited in Atkinson & Hammersley, 1998) that considering that we cannot study the social world without being part of it, in effect, any sort of social research is some form of participant observation. Nevertheless, Flick (2006, p. 220) describes participant observation as a process in which the researcher is increasingly participating in, and is gaining access to, the field of investigation and the people being researched. In doing so, the research focus is becoming more and more concrete.

During the academic year 2007/8 I was presented with an opportunity to conduct participant observation in an acupuncture course at a school for Chinese medicine. Since the BSc (Hons) Acupuncture was BAcC accredited as well as university validated, it provided me with a valuable insight into the challenge of introducing academic benchmarks into CAM education. As part of this participant observation I was able to observe the difficulty of teaching a technical kind of

knowledge in a traditional acupuncture course that is founded upon non biomedical principles. I was invited to join the academic team of the school and take part in the supervision and assessment of students' research projects which were undertaken as part of their final year of the course. My role, as part of the academic team at the school for Chinese medicine, was to supervise students writing their BSc dissertations, and to take part in the assessment and the evaluation of students' work. My participant observation included supervising six students, and, at the end of the academic year, the assessment and marking of 22 research dissertations as well as marking 12 oral presentations of the students' research projects. A year later, I came back to observe another set of students' presentations. During my visits to the school I conducted several interviews with school staff, including the school principal and two senior lecturers.

Participant observation has several unique features which suited my intention to bring the subjects of my research to the fore: it provides a window on meanings and interactions as they are viewed from the perspective of the studied population; it locates the investigation in a 'here and now setting'; it matches an inquiry which is flexible and open ended in its nature, such as an in-depth, qualitative approach; and it is often useful alongside other methods of data collection (Jorgensen, 1989). This participant observation of BSc (Hons) Acupuncture students' was particularly useful in exploring their experiences and perspectives in relation to the tension between technical and indeterminate kinds of knowledge that is part of formalising acupuncture education, and the way that holistic concepts and theories are negotiated alongside biomedical concepts.

The observation itself is described in depth in Chapter Six. It took place at an anonymised school that was founded as a college for acupuncture in 1992 by two 'charismatic teachers' (see page 65) who emphasised in their teaching the holistic aspects of acupuncture. In 2007 the school had approximately 400 students. The BSc (Hons) Acupuncture was first accredited by the BAcC in 1998, and several years later it was validated by a British university. My participant observation took place during the teaching of the unit Enquiry Skills, which is an academic descriptor, level six (the final year of the course) unit during which students are

introduced to scientific research methods. The ethos of the unit is 'evidence based medicine' and therefore the unit's focus is on the teaching of biomedical research and of randomised clinical trials (RCT's)[31]. During the unit students were required to develop an 'inquiry project', which is a critical review of the literature in relation to a clinical acupuncture concern.

Throughout my research the confidentiality of students and staff who I observed was maintained. Permission to observe the presentations was granted by 'Lucy', the school principal, 'Marilyn', the unit coordinator, and lecturers who were involved in teaching on the day that the presentation took place. Students were verbally informed of my presence as a researcher collecting observational data, as well as of the research aim, and, having been given the opportunity, did not object it. I will further discuss these ethical considerations in section 4.9 in this chapter.

4.6 Observations of acupuncture and homeopathy practice

As part of the exploration of acupuncturists' and homeopaths' holistic claims and holistic rhetoric, and in an effort to consider the relationships between such claims and actual practice, I conducted two non-participant observations of practice. The two observations included a one-day observation in an acupuncture practice and a one-day observation in a homeopathy practice. The acupuncture practice observation took place in a 'holistic centre' in an urban setting, where the practitioner I was observing, 'Lucy', shares her practice with other CAM and non-CAM practitioners. Prior to my observation, Lucy signed an informed consent form, and she attained verbal consent from her patients, allowing me to attend the treatment sessions. I was scheduled to observe five patients, but I actually observed just three sessions. As often happens in practice, one patient cancelled her meeting at the last minute, and when I realised that one of the other patients was a work-colleague of mine, I decided not to attend his session. Nevertheless, I

[31] RCT is an experimental design used for testing the effectiveness of a new medication or a new therapeutic procedure. Individuals are assigned randomly to a treatment group and a control group and the outcomes are compared. RCT is the most accepted scientific method of determining the benefit of a medical intervention.

found the experience insightful, mainly in demonstrating the role of rapport in the medical encounter and in particular in the context of acupuncture's holistic discourse. I describe part of the observation in Chapter Five.

As for my homeopathy observation, which involved significant travel, despite the generous support I received from 'Martyn', a homeopathic practitioner, I found it difficult to attain patients' consent to allow me to attend the homeopathic consultation. It is very possible that this was to do with the very intimate nature that is often part of this encounter. Eventually, I arranged to observe three homeopathic consultations over two different days. Once again, a patient cancelled her meeting at the last minute, and I observed one consultation rather than two that day. To my disappointment, on my second journey to observe Martyn in practice, due to major traffic delays caused by a large music festival in the vicinity of Martyn's practice and held on the day of my observation, I arrived late and missed the consultation. During these observations I recorded data by taking brief notes describing what I observed, including verbal and non-verbal communications. After each observation and as soon as I could, guided by the notes I took during the observation, I wrote a report of the observation in as much details as possible. At this point, I read the report several times, considering my observations in relation to the research questions.

In summary, observational data were difficult to collect. There were difficulties involved with arranging such observations. It was difficult to recruit practitioners who agreed to take part in this stage of the study mainly because they were worried that they might place their patients in an uncomfortable situation. Placing a strange person in the consultation room can interfere with the establishment of rapport between the patient and the practitioner, an important part of the therapies' holistic approach. Although consent was granted to me by both the practitioner and the patient, I could sense that my presence in the room, albeit quiet and 'passive', had altered somewhat the natural rapport between the patient and the practitioner.

4.7 Review of interviewees' websites and of BAcC/SoH schools' websites

The internet can be seen as part of a social construction and as a kind of environment in which the researcher can witness and analyse the ways participants negotiate meanings and identity, and how relationships and communities are developed (Markham, 2004). One of the ways of utilising the internet in research is 'to study sociocultural phenomena that are mediated by, interwoven with, or rely on the internet for their composition or function (Markham, 2011, p.112)'. Such research focuses on the way that a certain group of people utilises various aspects of the internet, or the cultural formations that are made available through it. However, the term 'Internet' serves as an umbrella term to a large number of technologies, capacities and social spaces, such as blogs, Facebook, chat rooms etc., and therefore it is important to narrow down the description of how the internet is utilised in a particular study (ibid). In this research study the internet was used to consider data that was published online by acupuncture and homeopathy schools and individual practitioners. To a certain extent, this data is rather 'static' (compared with chat rooms or blogs for example, where there is an ongoing correspondence and discussions) and is quite similar to other documentary analysis in that it contains, especially in the case of schools, formal and informal written documents and information. Nevertheless, it provides a contemporary snapshot into the way practitioners and their schools chose to present themselves to 'the outside world'.

Many acupuncture and homeopathy schools present documents and information such as courses' syllabi, courses' content, descriptions of therapies and interventions, information about the school (such as the style of practice being taught and the school's approach to teaching and learning), information about RCTs on acupuncture/homeopathy, and information about the staff and lecturers at the school. Typically, individual practitioners provide less structured textual information on their websites, although many do make links to data such as acupuncture/homeopathy research findings, information about the therapy or therapies being practiced and information about conditions being treated. Some practitioners tend to highlight esoteric and holistic concepts, while others emphasise research and RCTs and avoid discussing in length non-biomedical

concepts. Much can be learned from both schools' and practitioners' websites, about the way that the tensions that are part of professionalising NMQ acupuncture and homeopathy are negotiated, and about the way in which the holistic discourse is shaped as part of these strategies.

Practitioner's websites

In this study practitioner's professional websites provided an important window on the exploration of their practice culture and on the way that they present their practice to the 'outside world'. In particular this method was useful in observing practitioners' holistic discourse, and the ways that this discourse reflects the negotiation of challenges and tensions that are part of professionalisation. Most striking were the presentation of non-biomedical/biomedical concepts, the degree of the holistic engagement, and the level of emphasis on esoteric knowledge, as part of the 'practice appeal' that was created by the individual practitioner. Most of my participants had their own websites on which they presented themselves to potential customers and competed for clientele. Such websites typically include a description of the practiced discipline, the practitioner's biography and educational background, a description of a typical consultation, fees, and list of conditions which can be treated at the practice and often findings from RCTs which support their practice. The way practitioners described their practice on their website often included several holistic claims.

The data presented in these websites is not vast, which made it possible to review the whole information of all the available websites. While reading the text I identified paragraphs which were linked with the research questions. For example wider self or wider world holistic claims, reference to higher education, reference to professionalisation of practice, etc. I then printed these paragraphs and examined the data in relation to the categories that were used to analyse the interviews data, noting the specific category next to a corresponding text in the website. This allowed me to later integrate data from websites with other empirical data. Moreover, I often used this data to re-visit and re-examine data that was

gathered during interviews. For example, in relation to the way practitioners conceptualise holism, 'Ruth', an acupuncturist, described acupuncture on her website in a way which seems to suggest that there is a separation between physical, mental, emotional, and spiritual conditions - as if they are isolated from one another. Such presentation of acupuncture stood in contrast to the way Ruth described acupuncture in the course of our interview. During the interview she described acupuncture according to the holistic concepts that a) body, mind, and spirit are seen as interrelated rather than independent from one another, and b) treating the patient's 'constitution' rather than treating isolated conditions (Fulder, 1996, Goldstein, 1999).

Homeopathy and acupuncture school's websites

Both acupuncture and homeopathy schools vary greatly in the way information is displayed and in the content and 'spirit' of the text presented. Since, as I already discussed, there is a range of practice styles and approaches taught by the different acupuncture and homeopathy schools, each school presented itself differently. This was evident in the kind of language used (i.e. formal or informal, degree of esoteric claims, degree of spiritual content, or the degree of academic language used), and in the depth of information provided in relation to biomedical and non biomedical concepts. In the case of acupuncture, courses' information was more standardised than in homeopathy in the format and the degree of information provide as part of the courses' syllabi. All acupuncture courses provided an in-depth description of the course content, and a description of what is taught in each of the units. This was not always the case in the homeopathy schools, where the degree of information provided in relation to courses' content varied. Overall, I reviewed 27 schools' information and syllabi. Here too, the data was insightful in considering the way that acupuncture and homeopathy schools negotiate the tensions that are part of professionalising, including the diversity of theories and practice approaches, the ambivalent feelings towards biomedical knowledge and RCTs, and the way that the holistic discourse is shaped.

When reviewing this on-line data, although the information of each website is far greater than the information presented by individual practitioner's website, I read through all of the displayed information. In particular, I paid careful attention to the school's prospectus and to the acupuncture/homeopathy course syllabus and course content. Here too, I first read the information in relation to the broad research questions. I then re-read the printed data, noting paragraphs and information that corresponds with the research categories that were used in the interviews data. When information was not available on the school website, I contacted the school and requested the course prospectus. While practitioners' websites mainly provided insights into the way practitioners utilise and perceive holism, school's websites were a rich source of data for exploring the school's 'holistic ethos'; the degree of formalisation of courses in that schools; comparing and contrasting course content in different courses; and the way that technical and indeterminate kinds of knowledge were negotiated on the course.

All acupuncture schools provide online access to course prospectuses. These invaluable sources of information provided an opportunity to explore both the degree of holistic engagement in the course delivery, as well as the way biomedical and non-biomedical subjects are represented and negotiated on the courses described. In the case of homeopathy, in most instances, this kind of information is not as well presented and is not always made as available as it is on acupuncture courses. Still, most homeopathy courses provided some description of the course structure, and when not available electronically, the schools were happy to send me this data by post. I will now continue to describe the use of another important source of data, the BAcC and the SoH accreditation and educational documents.

4.8 Review of BAcC and SoH accreditation and educational documents

As noted by Flick, 'documents can be instructive for understanding social realities in institutional contexts' (2006, p. 252). Since the research interest was in aspects of acupuncture and homeopathy's professional projects and the formalisation of their educational structures, it was imperative to review the therapies' professional

bodies' guidelines in relation to these processes. After all, it is the professional body that drives and shapes the process at the formal level. Moreover, professional bodies' websites also provided an insight into the therapies' holistic discourse and its place as part of formal educational guidelines and protocols.

Formal educational and practice guidelines are published on the BAcC and the SoH websites. In the case of acupuncture, such documents were also published by the British Acupuncture Accreditation Board (BAAB), which is the accreditation arm of the BAcC. The documents were selected on the base of the information that they provide on acupuncture/homeopathy formal education and practice guidelines, in line with the research interest in the therapies' professionalisation and formalisation of education.

The following acupuncture documents were reviewed:

- *BAAB Accreditation Handbook (2010)*
- *BAcC Standards of Education and Training for Acupuncture (2011)*
- *The BAcC Standards of Practice for Acupuncture (2009)*
- *The BAcC Code of Professional Conduct (2004)*

The following homeopathy documents were reviewed:

- *The SoH Education Policy (2006)*
- *Aiming For Excellence: Homeopathy and Higher Education (2009)*
- *Clinical Education Guidelines (2010)*
- *Code of Ethics and Practice (2010)*
- *Skills for Health: National Occupational Standards for homeopathy (2009)*

I read each document, and extracted sections that were relevant to the research questions. I then re-read the text and marked sections and sentences that corresponded with the categories that are presented in figure 9 (see Chapter Six). For example, in relation to the inclusion of 'indeterminate in nature' and non biomedical kind of data as part of acupuncture formal education, the BAcC document 'Guidelines for Acupuncture Education' states the following:

> The practice of acupuncture is informed by values and principles which include the following. It seeks to be: ... *Holistic* - because treatment is based on an understanding that mind, body and spirit are integral, acupuncture can offer the possibility for (re)discovering what it might mean to be fully oneself. ... *Dynamic* - an awareness of rhythm, flow, balance, harmony and resonance, and the ways that changes in seasons and cycles of life inform both diagnosis and treatment. [Emphasis in original]

Such a commitment has significant meaning when it appears as part of an official professional document. Moreover, data from formal documents was a helpful triangulation tool. For example, in this case I was matching the data to acupuncturists and homeopaths narratives. For example in its document The Standard of Practice of Acupuncture (British Acupuncture Council, 2011) the BAcC demonstrates awareness of wider world holism. However, there seems to be a gap between the position of the professional body and the lack of awareness of wider world holism in practitioners' narratives.

I will now continue in the final section of this chapter to consider the ethical considerations of the research.

4.9 Ethical considerations

Principles of research ethics require researchers to ensure that participants in their study are protected from harm by taking into consideration participants' needs and interests (Flick, 2006). It requires researchers to ensure that the research is based on informed consent, that participants' privacy is not invaded and that they are informed about the research aim. As pointed out by Silverman (2011, p. 87), during social research the researchers are in danger of being so preoccupied with using the right methodology and with the process of data analysis, that there is a danger of losing sight of human issues of values and ethics. In particular he highlights two questions: first, the contribution of the study to a common good, rather than a mere interest in developing the researcher's career; second, whether do researchers want to help in one way or another the people they study and do the researchers protect their study participants.

Silverman (2011, p. 97) suggests a number of ethical safeguards that are required as part of an ethical research: ensuring that people participate voluntarily, making participant's comments and behaviour confidential, protecting participants from harm and ensuring mutual trust between the researcher and the participants. The main ethical considerations relevant to this study were informed consent; data management and confidentiality; as well as my 'positions' in relation to the research, as a former CAM practitioner, a university lecturer teaching on allied to health courses influenced by conventional medical practice, and as a PhD researcher. In relation to confidentiality, there are a couple of ethical concerns in particular that should be considered carefully: the utilisation of online data from practitioners and schools' websites, as well as the vulnerable position of CAM practitioners.

Ethical approval

Ethical approval was granted first by the School of Health Sciences and Social Work Ethics Committee at the University of Portsmouth (August, 2007), as well as by the NHS National Research Ethics Service (NRES), Southampton and South West Hampshire Research Ethics Committee (A) (see appendix 3). The reason for applying for NRES approval arose from the intention to interview practitioners who were also NHS staff. This ethical approval was granted on 22nd February, 2009.

Data management and confidentiality

In discussing the importance of confidentiality in this study it is important to consider the vulnerable position of NMQ acupuncturists and homeopaths. As discussed in Chapter One, both practitioner-groups are under ongoing attacks from parts of the medical establishment, parts of the media, and by sections of the academia. The latter, with particular references made to the criticism by Colquhoun (2007, 2008), was a concern that was expressed by some of the study participants, in relation to the attacks on CAM courses taught in British

universities, which I discussed in Chapter Three. Particularly in relation to confidentiality it is important to consider internet data which raises a number of research ethics concerns. Much of these concerns are with regard to Internet communities, such as chat rooms and discussion boards (Eysenbach & Till, 2001). For example, Hookway (2008) discusses ethical dilemmas concerning consent for online blogs. Some researchers argue that archived material on the Internet is publicly available and that therefore participants consent is not necessary. Others claim that certain online information is placed on the internet with an expectation of privacy. In this research study I did not use media such as blogs and chat rooms, but rather data that was posted *to the public* by professional bodies, schools, and practitioners who took part in the study. Nevertheless, especially bearing in mind the vulnerability of CAM practice, it was essential to ensure that data presented in this thesis does not add to the 'fuel' used against CAM. Mainly it was important to avoid a situation by which practitioners or schools can be linked to pseudonyms and to direct quotes. Participant confidentiality was maintained by ensuring that no identifying data pertaining to interviewees was presented at any point or stage of the study. Participants were allocated pseudonyms, and names of schools and their locations were removed from the data altogether. On several occasions online quotes were re-phrased, or alternatively, were presented without mentioning the synonym to avoid linking online data with interview data in a way that would have exposed the practitioner's identity.

The research was registered with the University of Portsmouth's data protection officer. All data was kept in a locked filing cabinet to which only I had access and which was securely located in a university office.

Informed consent

Written consent forms were completed prior to the commencement of all interviews. An information sheet describing both mode and purpose of the study and containing my own contact details and those of my director of studies were

provided to all participants prior to the interview. Participants signed the informed written consent form prior to the interview and returned it to me.

It is important to pay special attention to informed consent in observational data that was used in this study and the need to ensure that consent is given by the study participants to allow the use of this data. Walsh (2004) distinguishes between two research settings in participant observation: 'public' settings where access is freely available and 'private' settings that are controlled by gatekeepers (such as organisations) as in the case of the acupuncture school in this research study. Access to the research setting can be done 'covertly', without subjects' knowledge, or 'overtly', based on informing the subjects of the research and getting their agreement through a gatekeeper. In the case of my participant observation I obtained verbal consent for collecting observational data from two gatekeepers, the school principal and the unit coordinator, who then obtained verbal consent from the students for me to be present and collect observational data during both sets of observations. Students were informed about the purpose of the research, and having been given the opportunity, did not object my observation or the use of this data in my research. I obtained a letter from the unit coordinator to confirm this process of verbal consent. Hammersley and Atkinson (1995, p. 78) highlight the importance of trust in such an observational encounter, and the degree to which the subjects of the research trust the researcher. My CAM background (which I described to the students I supervised and to the school's academic staff) and the fact that I temporarily joined the academic team, were helpful in instilling such trust. At the same time, it is important to ensure, since individual consent forms were not used during the observations, that no direct quotes made by students during presentations or in their written assignments, were used.

Insider/outsider status: between CAM practice, biomedicine, academia and research

While traditionally ethical considerations related to qualitative research evolve around informed consent, the right to privacy and to protection from harm, there are several other important considerations to bear in mind (Fontana & Frey, 2003, p. 88). One of them concerns the researcher's degree of involvement with the study, something that is often referred to as 'positionality', or the 'insider/outsider' position of the researcher in relation to the topic of investigation and the participants. The notion of positionality is based on the assumption 'that a culture is more than a monolithic entity to which one belongs to or not' (Merriam et al, 2001, p. 411). This position is determined by the researcher's stand in relation to the people who are being investigated, which is a relative position that can shift in the course of the study. Rosaldo argues that a social analyst can rarely, if ever, be an objective, detached observer:

> There is no Archimedean point from which to remove oneself from the mutual conditioning of social relations and human knowledge. Culture and their 'positioned subjects' are laced with power, and power in turn is shaped by cultural forms. Like form and feeling, culture and power are inextricably entwined. In discussing forms of social knowledge, both of analysts and of human actors, one must consider their social positions. What are the complexities of the speaker's social identity? What life experiences have shaped it? Does the speaker speak from a position of relative dominance or relative subordination (Rosaldo, 1993, p. 169).

Between 1992 and 2001 I was deeply engaged in CAM training and practice. First, as a dedicated CAM student studying on a four-year, full-time naturopathy course, and then studying on a three-year, part-time homeopathy course. In 1996 I joined the chain of complementary medicine units of Israel's largest health provider ('Clalit Mashlima'), where I practised as a naturopathic practitioner until 2001. During this time I was also a lecturer in clinical nutrition and herbal medicine at the complementary medicine department of an academic college in Tel Aviv, Israel. However, in 2002, due to personal circumstances, I left practice and moved to the Netherlands, where I commenced academic education at Maastricht University, studying for a Masters in Public Health (MPH). Since 2004 I have been employed at the University of Portsmouth as a lecturer, first at the School of

Pharmacy and Biomedical Sciences, and from 2006, at the School of Health Sciences and Social Work. These biographic details drove me to conduct this research and, I believe, both informed and influenced my views about the subsequent data and engagement with the research process.

While reflecting on her ethnographic fieldwork on homeopathy, Barry (2002) describes how she was 'shifting identities' in the process of her ethnographic investigation. She describes how she was 'going native', gradually shedding her slightly sceptic, detached view of homeopathy, finding herself more and more fascinated by the therapy's concepts and the alternative lifestyle attached to it. At a certain point she contemplated commencing on homeopathic training and becoming a practitioner. She describes a feeling of growing alienation towards the academic life she was engaged in before starting her field work. While reading Barry's account I recognised that I was going through a similar experience, only in the opposite direction, from CAM practice to academia, and from being exclusively engaged in CAM to teaching on courses leading to mainstream biomedical professions such as paramedic science, operating department practice and human physiology. I started this journey with views embedded in CAM theory and practice, adopting negative views of conventional medicine and 'its reductionist nature'. However, this negative perspective of conventional medicine has somewhat changed during my public health studies which have brought with them an exposure to broad environmental concerns such as the cultural, sociological, geographic, economic or political aspects of health care delivery. Prior to this new exposure, during my years in CAM training and practice, I was largely unaware of such broad influences and their link to ill health. Moreover, as I entered academia as a lecturer, I found myself adopting a more critical and analytical approach to the generation and application of knowledge.

This, however, did not change my passion for CAM, but instead, I believe, inspired a more critical viewpoint towards some of my CAM 'roots'. Being a practitioner was not only about acquiring professional knowledge, but was also rooted in my enthusiasm as a practitioner and the way I projected this enthusiasm to my patients. It was also linked to my accumulating clinical experience, my

ability to establish good rapport with my patients, and even my intuition as a practitioner while considering practice options. This dilemma is discussed by George Lewith, a professor in health research from the Complementary Medicine Research Unit at the University of Southampton:

> The transition required from practice to research is complex and demands a very great deal of integrity and soul searching. If you begin with a belief system which is apparently effective for your patients, and furthermore provides with an income, then it becomes very difficult to challenge. … If you wish to remain an effective practitioner then undermining your belief system may make your practice less effective and indeed many would ask whether it is ethical to remain in practice. However, most thoughtful practitioners confront self-doubt about their clinical practice at regular intervals, particularly when they face complex and difficult clinical situations which are impossible to resolve (Lewith, 2004, p. 4).

It is clear to me that I entered this research with 'personal baggage' that could have had, and I am convinced indeed did have, an influence on my ability to conduct this study and consider its data. There are several issues in relation to my position in the research that I would like to consider. First, I entered the field of investigation with many preconceived notions which developed alongside my experiences in CAM practice. My initial challenge was to allow participants the freedom to tell their stories during the interviews and stop myself from constantly interfering and expressing my views. Second, the fact that I am based at a university may have intimidated some of the participants, and indeed several practitioners admitted their initial concern that my research may portray their practice in a negative light. In contrast, I hope and believe that my background in CAM practice, which I presented on my university profile as well as in my e-mail communication while approaching practitioners, put my participants at ease. I believe that my CAM knowledge and my practice experience allowed me to be both attentive and receptive during interviews to some nuances in relation to practice that perhaps would not have been otherwise.

In order to address this issue of to my positions towards my research, and maintain awareness of the potential impact this may have on the way I portrayed my findings, I worked to maintain a sense of reflexivity in relation to my own work.

I was doing so by periodically discussing my findings with two colleagues of mine, both sociologists who studied CAM. By discussing the aforementioned concerns with them, I was able to remain conscious of these concerns, and maintain, so I hope, a degree of good judgment and balance in relation to the data in front of me. The need to initiate more research from within CAM is well argued for by several CAM advocates and researchers, such as Vickers (1998), Peters (1998) and Lewith (1998). I believe that such research is essential for the healthy development of CAM practice.

In summary, this chapter has presented the multiple data collection methods employed in the research together with ethical considerations undertaken.

In the next three chapters, I will continue to describe and discuss the data that was gathered. In Chapter Five, I will explore NMQ acupuncturists and homeopaths' holistic discourse, and practitioners' reflectivity in relation to their holistic discourse. In Chapter Six and Chapter Seven I will examine the way this holistic discourse is negotiated as part of both therapies' efforts to formalise their educational structures.

Chapter 5

The holistic discourse: holistic notions in acupuncture and homeopathy

So far in this thesis I have described the background information to set the scene for the research; I have reviewed the literature and I discussed the theoretical and conceptual threads driving my investigation, as well as discussing methodological issues. In this chapter, the first of three empirical chapters, I will present and discuss my findings in relation to the following research questions.

5.1 Research questions addressed in this chapter

The research questions with which the data in this chapter corresponds are:

- What are the meanings attached to holism by practitioners, schools and professional bodies of NMQ acupuncturists and homeopaths in England?
- To what extent are NMQ acupuncturists and homeopaths in England reflective in relation to their holistic discourse?

In relation to the aforementioned research questions, this chapter draws on data from interviews with 25 acupuncturists and homeopaths, as well as data from the participant's own professional website, 14 BAcC and 13 SoH accredited school's websites, and the websites of both these professional bodies themselves. In order to present and discuss my findings, I will first map the theoretical and conceptual threads framing the research, and the contextual categories that I used to analyse the data. I will then continue to discuss the findings in relation to each category.

5.2 Mapping contextual categories

The contextual categories against which the data was considered derive from the literature and from the conceptual threads that were discussed in Chapter Two. In order to consider the data in relation to the aforementioned research questions, I will present two sets of categories. The first is a group of categories of holistic concepts in the context of CAM, and the second is a categorical group which derives from the literature which highlighted a number of challenges in these holistic concepts.

First categorical group: Categories of holism

As discussed in Chapter Two, when considering the literature, it is initially important to address what is often described as the lack of clear conceptualisation and misrepresentation of holism by CAM practitioners. Once this is considered, it is possible to view the various holistic concepts in the CAM context in two broad categories. The first category is that of holism in the context of 'the wider self', and the second, holism in the context of 'the wider world'. In presenting my findings I will use the following sequence:

a) Clarity of meanings and conceptualisation of holism

b) Categories of wider self holism

c) Categories of wider world holism

In reviewing the data, as can be seen in figure 7 (below), I left myself open to the expression of holistic concepts that were not discussed in the literature, although such new concepts did not emerge from the data. The following chart maps categories of holism against which the data in this research is examined:

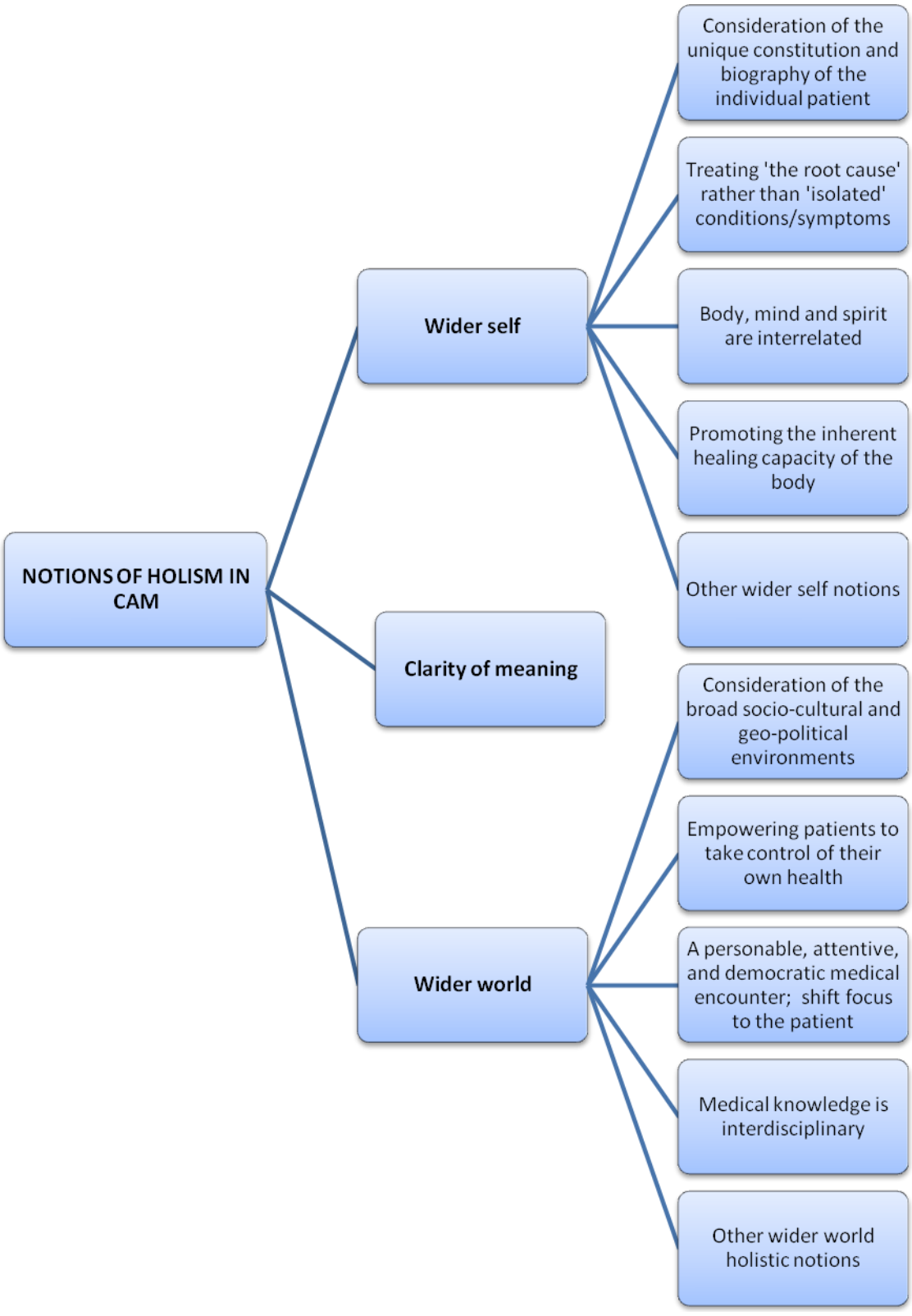


Figure 7: Categories of holism

Second categorical group: Categories of potential challenges in relation to the holistic discourse in CAM

The second group of categories against which the data is examined in this chapter is in relation to the critique of CAM's holistic discourse which highlights potential tensions inherent in these concepts. In the following chart I present these categories, again in relation to wider self and wider world holism. The chart below presents categories which derive from the literature:

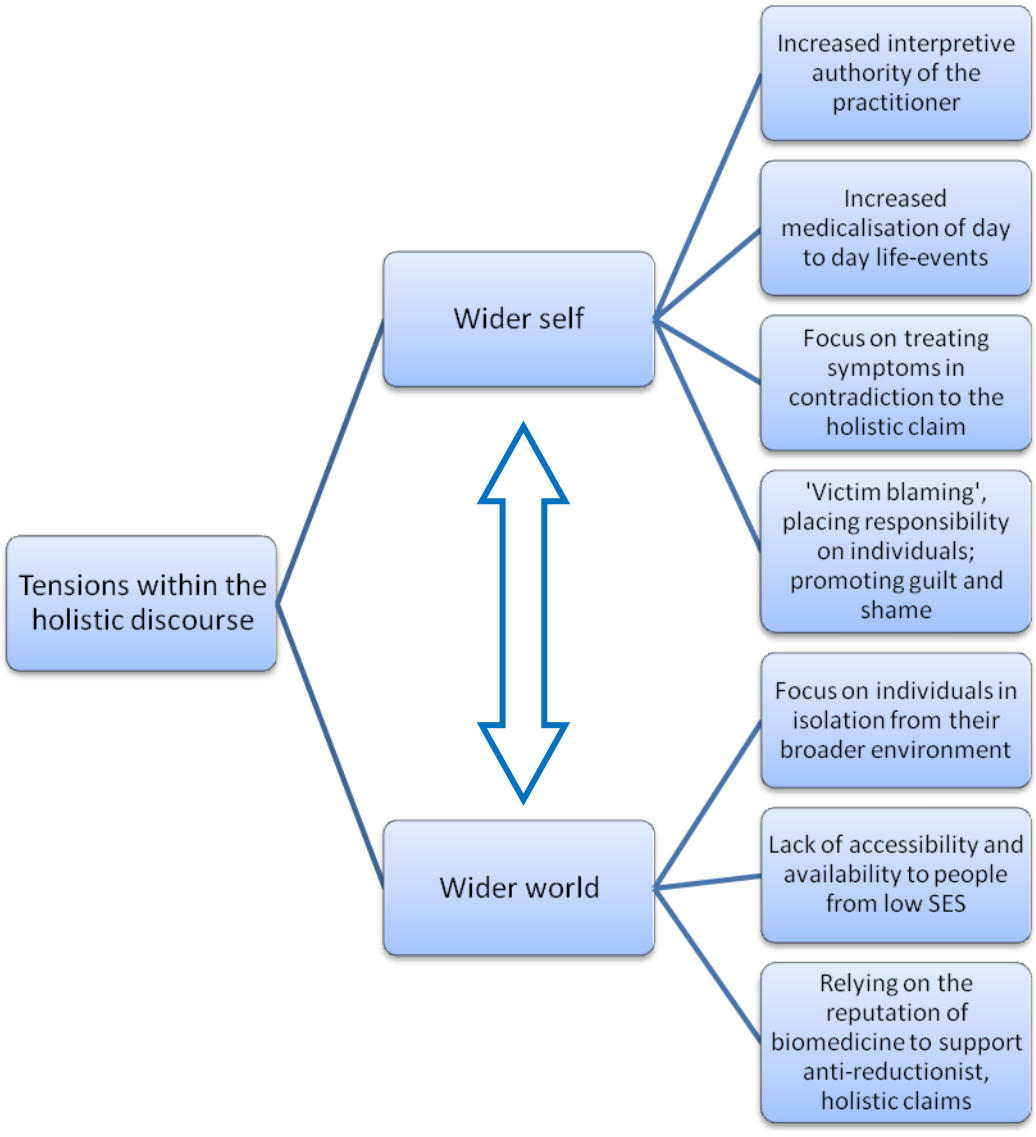


Figure 8: Categories of potential tensions in the holistic discourse in CAM

I will now continue to examine my findings in relation to the different contextual categories. It is difficult to separate between the holistic concepts and holistic perspectives that were presented by the study participants, and the way this holistic discourse is reflected in relation to the critique of CAM's holistic discourse. Therefore, over several sections, I chose to examine categories of holism (corresponding with figure 7), *alongside* the categories of the potential tensions inherent in these holistic concepts (corresponding with figure 8), and the way these categories are reflected in the data.

5.3 Clarity of meanings: practitioners' disillusionment with the term 'holism'

Approximately four decades after the proliferation of CAM as part of the medical counterculture, and despite significant changes in the nature of the CAM/conventional medicine relationship, the term holism is still widely utilised by acupuncturists and homeopaths to describe their practice. Much has occurred in the CAM arena since the days of the anti-reductionist movements of the mid-1960s and one may wonder whether this intense use of the term holism serves the same purpose as it did a few decades ago. As argued by Pietroni (1997) and Peters (1998), it often appears as if the concept is 'perpetuated' by CAM practitioners without real intent. There are several examples of this ambiguity of holism in the data. For example, the course information of one BSc (Hons) Acupuncture course makes use of 'holism' several times in relation to different units but without explaining its actual meaning:

> Course content: [The unit] 'Chinese Medicine Theory': ... the main focus of the module will be on the methodological training of the physiological body systems and the holistic understanding of health and disease. [The unit] 'Chinese Medicine Diagnostics'... focuses on the holistic ways of collecting clinical data for evaluating the conditions [The unit] 'Acupuncture Skill and Clinical Observation': ... Students will be required to demonstrate holistic and sensitive interaction with patients.

In this example it is difficult to follow what is actually meant by using the word 'holism', firstly in relation to the understanding of health and disease; secondly in relation to the way clinical data is collected, and thirdly in relation to the medical

encounter between the practitioner and the patient. These kinds of vague references may reinforce the frustration expressed by several practitioners in the previous section.

During my interviews with practitioners, discussions on the holistic nature of their practice required little prompting, and were naturally interwoven in their accounts. When reviewing online information published by practitioners, professional bodies and schools, holism was found to be continually mentioned. Nevertheless, the quotes below demonstrate certain disillusionment amongst practitioners of acupuncture and homeopathy in relation to the way that the term holism is utilised as part of the representation of their practice. Sue, an acupuncturist and a homeopath who runs two busy practices, and who is also a lecturer in one of the schools for Chinese medicine, argues:

> I think there's arrogance in the way that we use the word holism. I think that we feel we have a monopoly on it and it's becoming a very over-used and undervalued word which is a great shame. I think that the concept of holism as something that is more than the sum of its parts is a fascinating concept, but the word is just used and thrown around, used as a marketing tool. ... I have to say it's a word I feel saddened by these days, rather than inspired by it.

Sue, like several other CAM researchers and scholars, feels that holism is very often utilised in relation to CAM without clear intent, and that it has lost its meaning and purpose. Nicola, an acupuncturist and a school principal, expressed similar concern in relation to her students, fearing that holism, which she perceives as central to acupuncture philosophy and practice, has lost its meaning:

> This is why I agreed to do it this interview. Because I thought holism is such an interesting topic. I always hoped that one of the students at the college would take it up because that's where we all started from, and nobody knows what it really means. It is ridiculous.

Ruth, a homeopath, expressed a concern that practitioners' intensive use of holism as part of the rhetoric used to market their practice is a distraction rather than helpful. She argues that using holism to market homeopathy is distracting from the actual effect of homeopathy:

> The angle of holism, the nature of being holistic are all nice ideas, all great ideas, but I don't think that focusing on that does any favours for homeopathy because until more people can understand how effective homeopathy can be, I don't think in the UK it's going to grow.

In a rather humorous manner, Andy, a homeopathic vet, points at what he perceives as a common misrepresentation of holism:

> The word [holism] is often hijacked isn't it? I hate it when you see something like a holistic dog food because there is no such thing.

It is not unreasonable to assume that the changing attitude towards CAM from the medical establishment in the UK, and the efforts to professionalise acupuncture and homeopathy that followed, have inspired a change in the way practitioners perceive their relationship with conventional medicine. Indeed, while accounts describing CAM as an 'antidote' to the 'weaknesses of reductionist biomedicine' are not uncommon in the data, rather than criticising conventional medicine, many participants, adopted a less critical attitude towards it and towards its commonly mentioned reductionist shortcomings. Perhaps, then, if the anti-reductionist rhetoric is less apparent, it is important to consider why holism is still used so often by CAM practitioners. Sue argues that holism is used by CAM practitioners as a way of distancing CAM from conventional medicine, and, by that, developing their own identity. However, she argues, it is time to reconsider the utilisation of this concept as part of the CAM discourse. Moreover, she suggests that now that acupuncture is more respected as a profession, it is perhaps time to move away from the anti-reductionist rhetoric used by CAM practitioners to separate them from conventional medicine:

> When you don't have a strong identity as a group, it's like teenage boys – they don't know who they are. They identify themselves by what they are not. So they push away the other groups that they don't like, and maybe that's what complementary medicine has done, you know, 'we are not this reductionist approach; we are this holistic approach instead'.

> I think that holism has been over-marketed without a true concept of its meaning, so we need a new word now! So maybe we can let go of it, if we

> are becoming more defined as a group, if we are becoming more respected, maybe we don't need that concept so much anymore.
>
> Maybe that's partly why I feel I'm letting it out you know ... I'm letting go of it now, and I think there may be more specific and useful ways to define ourselves now. ...Western medicine is opening its arms a little bit to us and we are learning to be less like sulky teenagers and to be grown up about it.

Nevertheless, despite these expressions of discontent with the misrepresentation of holism as part of the description and the marketing of the therapies, I commonly encountered four holistic concepts in my study: (a) Body, mind and spirit are interrelated, although there is some obscurity in the way 'spirit' is described, and quite often 'emotions' is used instead of, or alongside, 'spirit'; (b) Consideration of the unique constitution and biography of the individual patient, and a tailoring of treatment so that it suits the unique makeup of each patient; (c) Promotion of the inherent healing capacity of the body; (d) A personable, attentive and democratic medical encounter, during which the focus shifts from the practitioner to the patient. Regarding the fourth holistic notion, practitioners did not always link this aspect with holism, yet it was almost always raised as a 'key ingredient' in holistic practice, and as something that distinguishes acupuncture/homeopathy practice from 'the reductionist' conventional medicine. I will now move on to consider each of the categories that I mapped at the beginning of this chapter.

5.4 Holism as the interrelations between body, mind and spirit

In the previous section I discussed certain disillusionment by some practitioners in relation to the use of 'holism' as part of the representation of their practice. Another area in the data which presented lack of clarity in the holistic discourse is the lack of clear conceptualisation of the body, mind and spirit interrelations. The interrelations between body, mind and spirit, was a very often mentioned holistic notion. It was remarked upon by nearly all of the study participants, and is also commonly mentioned in acupuncture and homeopathy schools on their websites. Still, as Scott (1999) argues, there is a certain vagueness and lack of clear conceptualisation of this particular holistic notion. For example, while the body/mind relationships seem to be quite well described in the literature, the

inclusion of ‘spirit’ in this equation is often unclear. As a result, while this model contests the body/mind dualism and the reductionist-materialistic tendencies of the biomedical model, it makes it difficult to understand *how* exactly it challenges the biomedical model. To demonstrate the lack of clarity in the way body, mind and spirit interrelations is conceptualised, I would like to compare the way that this holistic notion is described by three of my participants, all experienced traditional acupuncturists, all three are school principals of acupuncture schools in England. Jeannette has been practising acupuncture for 34 years. While describing the holistic nature of the BSc Acupuncture course taught at her school, her reference to ‘body, mind and spirit holism’ is inspired by the Five Elements practice style. While conceptualising the body, mind and spirit interconnection she is focusing on the individual’s ‘energetic character’ and constitution that is reflected in the energetic relationships between the five elements (fire, earth, water, metal and wood):

> Students are taught to look at the whole person and to make a diagnosis of the whole person. And that diagnosis will be, in terms of using the Five Element theory, that each person has one main element which has various different organs connected to it, which are primarily out of balance. ... once that’s been diagnosed and as the treatment progresses, then treating that particular area brings the whole person back into a better balance. It is based on the fact that the persons’ body, mind and spirit, all areas of the person can change, when the main thing that’s out of balance is put back into balance.

Nicola is the principal of another leading school for acupuncture and she has been practising acupuncture for 30 years. In her school’s website I found a more esoteric conceptualisation of the body, mind and spirit interconnectedness than Jeannette’s conceptualisation of it. Here, there is a description of a ‘holistic world’ which is manifested in an energetic connection ‘between people and the cycle of nature’. This energetic link influences the constitutional strengths and weaknesses of each patient.

I asked Nicola about the meaning of ‘treating the whole person’ as part of the college philosophy. Her description of the concept was intriguing, but it was different to that of Jeannette. It appears to involve more attention to the energetic

interaction between patients and their environment, rather than to the internal energetic imbalance as in Five Elements. At first glance it appears that her description is more attuned to a wider world holism and to the patient's environment, but on further scrutiny it appears that the attention on treatment is on re-establishing an individual's energetic imbalance. This does not necessarily involve increased attention to the patient's social, cultural or geographic, broader environment:

> The part in acupuncture which fascinates me is that there is a universal spark which started it all off, and acupuncture's not afraid to talk about that, or our college is not afraid to talk about that. Because that's where energy comes from and that universal spark is unique in each person and I think that's where 'holism' is linked to it. But then the philosophy goes on in heaven, earth, man and you can't have a heavenly influence without having a man or a woman, or a human being, or a creature. That's where 'holism' comes from, from my point of view, from that bigger universal spark.

The third school principal is Lisa, who has been practising acupuncture for 25 years. Her presentation of body, mind and spirit holism focuses on being able to understand the patient's perspective as closely as possible. Lisa's 'holistic narration' was different to most accounts I encountered in that it was more attuned to the position of individuals in the broader environment in which they operate – and not just in the energetic sense. In fact, it was a rather rare occasion when one of the interviewees made reference to this kind of wider world holism:

> I think had you asked me 25 years ago what I see as holism I would have said probably that the central thing for me [in] 'holism' is about seeing the patient for who they are. It may be about their emotional makeup, it may be about their physical makeup, it may be about their physical entity. It's about their totality.
>
> And for me holistic practice is about me understanding what that is that they presented to me and understanding it as closely in their terms that I can manage. And that's holistic practice.
>
> If you ask me how I see holism now, it has another aspect altogether. And that is the aspect of treatment of a patient within the patient's context so that is to say if you like 'integrated medicine'. So you can't divorce the patient from their life or from the culture that they live in or the world that

> surround them. ... So in another sense holism is about being able to embrace the patient's version of reality.

Lisa's account is different to that of the other two school principals in that it does not precisely follow the theoretical narrative of the practice style taught at her school in the way that Jeannette and Nicola did. Rather, it appears to me that her account is more personal and reflective, drawing on her own journey as a practitioner and an educator. Lisa points to another change in relation to the interrelations between body, mind and spirit. She describes what she feels is the difficulty of 'Western minds' to grasp this interrelation, which is more naturally embedded in some other cultures including in Eastern philosophies. She describes the challenge:

> I think that exactly reflects the very difficulty that we have. Unless you spend a lifetime steeped in Eastern philosophy, you come at it from a Western standpoint. And what you are seeing … you are putting together things that are separated. Whereas if you came at it from an Eastern standpoint, you would never have seen them as separate in the first place. So you wouldn't have seen a necessity to put them back together.

Indeed, some of the practitioners appear to recognise the importance of body, mind and spirit in relation to practice but without recognising *the interconnectedness* between them. For example, Ruth has been practising acupuncture for seven years. On her website she describes acupuncture as having to focus on improving the overall wellbeing of the patient rather than simply treating specific symptoms in isolation. However, her description of practice appears to divide between 'physical conditions', 'mental conditions', 'emotional conditions', and 'spiritual conditions' rather than describing them as linked with one another.

Marilyn was trained as a conventional doctor before studying traditional acupuncture. She became fully immersed in acupuncture, and is now a senior lecturer in one of the acupuncture schools. During the interview, she made reference to the way that the BAcC described acupuncture on its website as a way of 'treating the whole person to recover the equilibrium between the physical,

emotional and spiritual aspects of the individual'. In Marilyn's view, this description lacks the recognition of the interrelations between body mind and spirit:

> For me 'to recover the equilibrium not between the physical, emotional spiritual aspects of the individual' [as described by the BAcC website] sounds as if there is 'one body', 'one mind', 'one spirit', and they all have to be in equilibrium [as if] they are already separated. I don't separate it ... I don't think the Chinese have ever separated that.

Also in homeopathy different practitioners expressed different interpretations of the body, mind and spirit interrelations. For example Louise, who has been practising classical homeopathy for ten years, suggested that the terms may be perceived in a religious sense or as a New Age concept, which is not something she would like her practice to be associated with:

> Louise: I don't like the word spiritual, but it's sort of like working on the spirit energy which I think that's what's lacking in medicine.
>
> Interviewer: Why don't you like the word 'spiritual'?
>
> Louise: I think it's got all sorts of connotations which are misinterpreted, such as in the religious sense [and] that is not what I mean. When I talk about spirit, I'm talking about the essence of somebody that maybe does come from a far far higher place. Spiritual sounds like ...it's almost like a New Age religion and that's not something I'm comfortable with.

Sue sums up a concern over this lack of clarity of holism as the interrelations between body, mind and spirit with a plea for practitioners to clarify the meaning of this concept:

> I think that if you ask most people in the street what does [holism] mean, well they may say 'mind, body, spirit'. But they may not really be too sure what they're talking about. ... they would see it as a term linked to complementary medicine ... I think everybody knows that complementary practitioners are people who spend time with their patients and look at all aspects [body, mind and spirit]. I don't think that this is news to anybody these days so I don't think that we have to keep banging on about that. I think we maybe need to be more specific about what we do and where we go from here.

It could be argued that without a clear conceptualisation of the body, mind and spirit interrelations in the therapies' holistic discourse, this discourse may lose its credibility and its usefulness in promoting practice. For example, in the case of acupuncture, the body, mind and spirit interrelations, is a concept that is part of the BAcC standards of practice (British Acupuncture Council, 2009a, p. 3). Hence, there is a potential concern that practitioners who are members of the professional body will not have a shared understanding of this concept and its implication to practice. I will now continue to examine another holistic category which was commonly mentioned in practitioners' narratives, and which is closely linked with the body, mind and spirit interrelations, that of the individualistic nature of practice.

5.5 Considering the unique constitution and biography of the patient, and treating the 'root cause' rather than 'isolated' symptoms

In this section I would like to consider two categories together as they were often mentioned by practitioners as linked to one another. In describing the unique features of CAM, Fulder (1996, p. 5) argues that unlike biomedicine, CAM practitioners work to identify the root cause behind physiological symptoms rather than just suppressing them. He gives an example whereby a headache in a certain patient might be seen by the acupuncturist as related to a deeper rooted problem, such as poor liver function, or energetic obstruction related to the liver. Therefore using merely a painkiller will only suppress and 'hide' what is in effect a more significant problem. Related to this holistic notion is the idea that the acupuncturist or the homeopath (as in many other CAM) is looking to treat individuals on the basis of their unique biography and unique constitution (ibid). This focus in CAM on treating the individual person stands in contrast to the argument that biomedicine's focus on treating 'the disease' (Bates, 2002). The term 'constitution' refers to the individual features and unique characteristics of each individual, including personality, habits, physiological features, energetic balance/imbalance, which are linked to the patient's strengths and weaknesses. In order to treat the root cause rather than treating symptoms in isolation, the practitioner has to consider 'the whole person', with her/his unique biography and

constitution. This holistic perspective was very often discussed by practitioners during interviews and on their websites. It was also commonly mentioned in schools' and professional bodies' on line description of acupuncture/homeopathy practice. For example on the website of one school of Homeopathy, it is argued that the popularity of homeopathy derives from several unique features:

> You are treated as an individual, not as a collection of disease labels; homeopathy treats all your symptoms at all levels of your being – spiritual, emotional, mental and physical and finds the 'like cures like' match for them

On its website, the BAcC describes acupuncture's focus on the individual and the 'uniqueness' of the patient:

> The focus is on the individual, not their illness, and all the symptoms are seen in relation to each other. Each patient is unique; two people with the same western diagnosis may well receive different acupuncture treatments (British Acupuncture Council, 2007).

However, arguably, in contrast to the focus on treating the constitution of the individual person rather than treating 'the illnesses', nearly all of the study participants presented on their website a long list of conditions and symptoms that they offer to treat. There are many examples for this approach on the participants' websites. For example, Helen, who has been practising homeopathy for 27 years, describes homeopathy as treating the whole person rather than treating symptoms. However, at the same time she describes homeopathy as 'beneficial for specific conditions, for example during acute conditions, colds, influenza and inflammation'. Hence, she appears to focus on treating conditions rather than treating 'the whole person'. On her website Helen also presents a long list of conditions, which, again, may be seen as contradictory to the 'constitutional' treatment of the whole person. She lists a large number of conditions she treats in practice, including food allergies, a range of gastric problems, arthritis, Candida overgrowth, hay fever, asthma, depression, anxiety, and other specific health concerns.

It could be argued, as suggested by several practitioners, that this is merely a way of marketing their practice to a biomedically-accustomed public, and entering what is essentially a biomedically-dominated marketplace. Still, I encountered several unresolved contradictions, and a mismatch between the claim for constitutional treatment and the strategies employed in actual practice. For example, Martyn, who has practised classical homeopathy for 14 years and who co-owns a centre for holistic health, during our interview made several references to constitutional treatment, such as:

> What we're trying to find as homeopaths are the unique characteristic symptoms of that individual, by looking basically at the mind, body, spirit connection as much as the individualising symptoms that they come with.

However, when describing some of his patients, it appears as if in practice his approach is often symptomatic in nature. While he is clearly attentive to both emotional and physical symptoms, these symptoms are treated in isolation from one another. This contradiction is encapsulated in the following quote, in which Martyn describes how he treated a patient who suffers from Meniere's disease[32]:

> I treated the presenting symptoms so for the dizziness I prescribed Cocculus Indicus which is a snake remedy, fantastic for vertigo and dizziness and is concomitant to the dizziness. She had sickness and nausea so I gave her Nux Vomica. So alternately Cocculus Indicus once an hour and nux vomica as needed up to 3 doses a day. And because she got incredibly anxious and she suffers from hypertension, I gave her aconite. The aconite, as you know, is for shock, anxiety, and so on.
>
> She came back the following week. The symptoms of the Meniere's were less, but she was still being disturbed at night, waking up with sound, but there was some progress. And when I put my hands on her system there was less tension on the cervical spine. I just asked her to just add one remedy for her sleep problem, because she'd awake quite a lot, Avena sativa, which is wild oat, 15 drops in a mother tincture.

In the case he is describing, Martyn's treats symptoms in isolation, using a different homeopathic remedy for each symptom. He prescribed the patient with

[32] A condition of the inner ear typically causing attacks of vertigo, hearing loss, and tinnitus (noises in the ear).

one remedy for her vertigo and dizziness, another for her nausea, another for anxiety, and so on. Such an approach appears to contradict the constitutional premise of homeopathy which he himself was advocating during the interview.

Another example comes from Lucy's description of her own practice. Lucy is a principal lecturer and a senior researcher in biomedical science and immunology at a British university. She graduated as a traditional acupuncturist in 2007 and she is the programme leader of the conventional medical sciences in one of the acupuncture schools. While she describes traditional acupuncture as a 'powerful approach' which provides constitutional treatment, she also practises cosmetic acupuncture, which is more symptomatic in nature. Well aware of this dilemma, Lucy describes how she tried to resolve the tension between 'deep', 'constitutional' treatment, and 'superficial', symptomatic acupuncture treatment:

> I'm working on Saturday at the City Physiotherapy Centre and I'm working Mondays at a beauty place. They are two completely different environments. The physiotherapy centre is ... I will say kind of more medical. And then the beauty place [where Lucy practices cosmetic acupuncture] ...It is not just sort if nice spa treatments. They do Botox and peels and the whole lot so they're quite kind of full on, so you've got a completely different market base I guess there, so trying to fit the acupuncture practice in both ways is interesting.

During the interview it appeared that Lucy was conscious of the tension between her constitutional and symptomatic practice approaches. On one hand she describes acupuncture, and in particular the Five Elements style of practice, as holistic in its capacity to treat 'the root cause' on a 'constitutional' level. On the other hand she 'lowers' the degree of her holistic engagement and treats more 'superficially' during her cosmetic acupuncture treatment. The degree of holistic engagement in practice is not constant and can change in relation to the patient's perspective, the practitioner's approach, the medical concern being addressed, or the style of practice. For example, the way Martyn and Lucy may chose, at times, to work on a more symptomatic level (rather than treating the 'root cause' and take into account the patient's constitution), can be seen as lowering their holistic engagement. However, at the same time, while observing their practice, I have noticed how both are extremely attentive to their patients' biography, are very

empathic, and are doing their best to ensure that their patients feel listened to and cared for, which can be seen as intense holistic engagement.

Another practitioner is Chris, who was trained first as a classical homeopath and later as a traditional acupuncturist. I asked Chris about the factors which determine his choice of either acupuncture or homeopathy. In reply he argued that the condition that is being treated is the most important 'ingredient' in determining his therapeutic choice. Moreover, he suggests that the condition being treated also determines the degree of his holistic engagement:

> I suspect that homeopathy has its strength in certain conditions and acupuncture has its strength. ...I feel confident treating people homoeopathically with more systemic conditions: hay fever; allergic conditions; skin conditions; possibly certain digestive disorders; and children as well. Acupuncture is very effective with muscular and skeletal conditions and pain related conditions. So depending on the condition I am very happy to integrate both of them.
>
> If somebody came to me with eczema I would feel more confident treating them with homeopathy. But if they came to me with back pain I would feel more confident with treating them with acupuncture. So it is definitely depends on the condition.
>
> If somebody comes to me with back pain I would tend to say it is less holistic. I would probably tend to use certain points-protocols and not take into account so much the holistic view. But if somebody came to me with eczema, then it would be more holistic.

Chris's approach is somewhat contradictory to the holistic notion of treating the patient's individual constitution. Rather, he emphasises 'the condition' as the main force driving his treatment approach. Clearly, some practitioners are more engaged with constitutional treatment than others. Moreover, while the style of practice may significantly impact on the degree of holistic engagement, some practitioners feel more comfortable with a certain style of practice which suits their own 'practitioner constitution', influenced by the practitioners' own biography.

Practitioners' narratives point at the complex and conflicting position that they find themselves in relation to consumers' expectations on the one hand, and their 'loyalty' to their holistic philosophy on the other. This (and I will present other perspectives in relation to it in this chapter) leads NMQ acupuncturists and homeopaths to develop a kind of 'pragmatic holism', which is the presentation and application of practice in relation to a number of factors, including the practice setting, consumers' expectations, and a number of practice-related and professionalisation strategies. In fact, practitioners maintain a dynamic, flexible approach to practice to adhere to a highly complex practice-environment. One of the most striking tensions is between adherence to 'the medical model' and maintaining the holistic ethos and the unique nature of the 'traditional', esoteric expert knowledge of acupuncture and homeopathy. It seems that practitioners also have to negotiate complex consumers' expectations in relation to their practice, which may explain the shift between 'constitutional' and 'symptomatic' treatment in the representation of practice.

While surveys suggests that users appreciate lengthy, personalised, more 'democratic' client-practitioner encounters which are responsive to their views and needs (Ong & Banks, 2003), the common pattern is of combining both conventional medicine and CAM (Thomas & Coleman, 2004). This suggests simultaneous use rather than 'replacing' biomedicine with CAM, and a 'mix and match' approach of potentially contradictory medical knowledge in search for an effective and satisfying service (Cant, 2009). One of the questions is how much esoteric knowledge, or how much biomedical knowledge should be expressed in the representation of practice, and it seems that practitioners are trying to adopt a strategic approach and negotiate both. Perhaps by that they maintain an appeal to consumers who look for a 'responsible', biomedically-informed practitioner, as well as a 'true' holistic practitioner. I will return to this matter later in this chapter. I will now continue to discuss another holistic category: that of enhancing the body's natural healing forces.

5.6 Promoting the inherent healing capacity of the body

Linked to the holistic view of each patient as unique and the individualised nature of acupuncture and homeopathy are the views that our bodies and life processes are more than mere biochemical and biophysical mechanisms, and that our bodies are equipped with an inherent healing wisdom (Rosenberg, 1998). This notion points to the way that the body, as a whole, is able to adapt and respond to various circumstances and threats, and that the role of the acupuncturist or the homeopath is to promote this natural tendency (Fulder, 1996), rather than providing a medical intervention that works instead of this natural healing tendency. For example, the acupuncturist will often aim to improve the flow of a certain kind of *qi* which in return will improve the body's ability to resist external pathogens rather than prescribing a drug that will kill the bacteria. This kind of holism was very often mentioned in online information published by both the professional bodies and the schools. The first example is taken from the website of the SoH and the second from the BAcC:

> A system of medicine which involves treating the individual with highly diluted substances, given mainly in tablet form, with the aim of triggering the body's natural system of healing (Society of Homeopaths, 2011b).

> By inserting ultra-fine sterile needles into specific acupuncture points, a traditional acupuncturist seeks to re-establish the free flow of *qi* to restore balance and trigger the body's natural healing response (British Acupuncture Council, n.d.).

It was made apparent to me during the research that the way of enhancing the patient's natural healing capacity varies greatly according to the style of practice being taught at the different acupuncture and homeopathy schools. I would like to take the opportunity to discuss this issue, which seems to be significant in determining the kind and the degree of holistic engagement enacted by the individual practitioner.

5.7 The impact of the style of acupuncture/homeopathy practice on the holistic engagement of the practitioner

In Chapter Three I briefly described the main styles of traditional acupuncture and homeopathy that are practiced in the UK. As argued by Birch (1998) in relation to acupuncture, and by Swayne (1998) in relation to homeopathy, different theories and styles of practice involve greater holistic engagement than others. Indeed, throughout my research I encountered several examples of the impact of the adopted practice style on the degree of engagement with holism by the individual practitioner. Despite the therapies' movement to more formalised educational structures, the presence of 'charismatic teachers' (see page 68) in acupuncture and homeopathy is still evident. The different acupuncture and homeopathy schools teach a range of practice styles and theoretical approaches. This is not surprising, bearing in mind that both therapies have such wide theoretical basis, and, in particular acupuncture, with its ancient history and diverse historical roots, has many interpretations to the way it is practiced (Birch, 1998).

Moreover, it is possible that the highly indeterminate nature of the therapies' knowledge leaves plenty of room for individual interpretations. Homeopath interviewees often referred to this 'amazing' teacher or the other, such as Rajan Sankaran, George Vithoulkas, Jeremy Sherr, Miranda Castro and many others. Each of these charismatic teachers is affiliated with a unique approach to practice that is adopted (or rejected) by the homeopathy schools, regardless of the formality of teaching in that school. Similarly in acupuncture, Giovanni Maciocia, Jack Worsley, Stephen Birch, Johan Van Buren and others developed diverse interpretations of significant elements in practice (as shown by Birch, 1998), with different schools in the UK following the tradition of a certain charismatic teacher or another. Let me now demonstrate the impact of the practice style taught at different acupuncture and homeopathy schools on the holistic engagement of the practitioner. Lucy studied an approach which integrates the 'more holistic' and 'constitutional' Five Elements style with the more 'symptomatic' and 'less holistic'

Traditional Chinese Medicine (TCM) style. She describes how using one style or the other would impact on her holistic engagement in practice:

> If you get it right, Five Elements is amazing. *It's a constitutional treatment* so they [patients] will feel so much better. *You know you can transform their lives* so to speak in the way that they feel and their outlook.
>
> But, if they've got arthritis, you might not do much about that so the TCM can kind of address that side. ... TCM - and I'll probably get shot by TCM practitioners for saying this, is very good at *addressing the external causes and miscellaneous causes, but possibly weaker on the internal causes*. Five Element is more [effective in treating] the internal and weaker of the other two, if you see what I mean [My emphasis].

In fact, one of the acupuncture schools developed this integration of styles in order to allow practitioners to choose the style of practice which they feel is suitable for the case and for them as practitioners. By that they offer the practitioner flexibility in the degree of holistic engagement she/he chooses to adopt in practice. The impact of practice style on the degree of holism in practice is also present in homeopathy. As described in the introductory chapter, the main approaches include the 'classical' approach that remains loyal to the 'original' Hahnemanian principles and a range of 'practical' or 'clinical' practice approaches which find classical homeopathy to be an idealistic, yet not practical, approach (Jonas, Kaptchuk & Linde, 2003).

Some practitioners, however, may first use a more symptomatic approach in that they will look for a remedy that will address the condition rather than the patient's constitution. Only if happening to come across very peculiar symptoms, (say the patient loves walking nude on the beach, gets emotional when by the sea, and enjoys very greasy food – all pointing to a particular 'constitutional remedy'), then the practitioner may use a particular constitutional remedy. On the other end of the holistic spectrum we find the 'combinations' homeopathy approach, which is the use of a combination of homeopathic remedies, assuming that several remedies together are more likely to cover the symptomatic variations of clinical conditions. In effect, other than using low or invisible pharmacological potencies, this approach is quite similar to that of conventional medicine, and is mainly used

to treat symptoms. Furthermore, one eclectic approach to homeopathy is 'complex homeopathy', which is widely practised in Germany and continental Europe, and which involves using a number of different remedies, including traditional homeopathic remedies as well as biological preparations in order to bring about detoxification of the body, together. The latter approach is a combination of homeopathy, naturopathy and biomedicine (Ernst and Schmidt, 2004). Moreover, in practice, practitioners may use various 'add-ons' to the classical approach, such as using metaphysical principles to find the right homeopathic remedy, or use electronic devices as part of the diagnostic process (Jonas et al., 2003, p. 394).

While all practitioners in this study were initially trained as classical homeopaths, not all remain loyal to its pure form, adopting additional, more 'practical' approaches. Phil was a paramedic for 25 years before deciding to change his career and become a homeopath. While reflecting on his training at the homeopathic college, he describes how some colleges teach more contemporary approaches to practice while others, which he refers to as 'rigid', maintain the teaching of classical homeopathy in its 'pure form':.

> Nine times out of ten people want a quick result. I wasn't taught just classically, I was taught to use combination remedies. I'll use things like herbal tinctures - not all homeopaths do. I use a lot of support remedies - not all homeopaths do. But there are some very rigid classical colleges around the country, and whilst the students have got a good classical knowledge, when they actually start to practice, they then have to find what works and what doesn't work.

The relationship between the style of practice and practice representation in acupuncture and homeopathy was noted in a number of studies. In my research I focused on the holistic discourse and how the style of practice taught in different acupuncture/homeopathy schools, and adopted by the individual practitioner, influences the degree of the practitioner's holistic engagement. Welsh et al. (2004) interviewed leaders of acupuncture and homeopathy in Ontario, Canada, discussing the variability in schools' curricula, and how each has its own version and tradition of practice. They point out that much of the internal friction within

acupuncturists is over ‘who should be able to claim the knowledge base’ (ibid, p. 226). Some link high standards of education with increased teaching of biomedical science and medical training, while others emphasise traditional Chinese medicine-based knowledge to demarcate the ‘true’ acupuncturists from the ‘pseudo-acupuncturists’. According to Welsh et al. similar debate is taking place in relation to homeopathy. It seems that a high level of biomedical knowledge is linked with safe practice and with a ‘trustworthy’ practitioner who has ‘knowledge of both world’, the biomedical one and the esoteric one. In contrast, a high level of esoteric acupuncture/homeopathy knowledge is linked with an in-depth ‘professional competency’ and practitioners’ orientation and knowledge of the ‘pure’ form of ‘true’ acupuncture/homeopathy. I will return to discuss the tension between biomedical and ‘traditional’/esoteric knowledge and demarcation of expert knowledge further on in this chapter, when discussing the infusion of biomedical concepts into the holistic discourse.

In the next section I will use the data gathered from a small sample of members of the Acupuncture Association of Chartered Physiotherapists (AACP) to extend the discussion on the impact of practice style over the degree of holistic engagement.

5.8 ‘Pragmatic holism’: Acupuncture practitioners, members of the Acupuncture Association of Chartered Physiotherapists (AACP)

In the following section I will discuss data from interviews with four physiotherapists who practice acupuncture as part of their NHS physiotherapy practice in four different settings, addressing their holistic narratives. I am aware that this section of the data is a slight deviation from the main focus of the research on NMQ acupuncturists and homeopaths. Nevertheless, as will be evident from the following data, this perspective provides an illuminating comparative angle, which helps examining the nature of the holistic discourse and considers the challenges and strategies that are negotiated as part of this discourse in relation to practice.

Acupuncture has become a popular modality in physiotherapy, mainly in relation to pain relief, and it is increasing in popularity in physiotherapy outpatient departments in Britain (Kerr, Walsh and Baxter, 2001). According to the AACP, there are more than 6,000 physiotherapists who use acupuncture in their practice (Acupuncture Association of Chartered Physiotherapists, 2011). These practitioners are members of the AACP, which is affiliated with the regulating body of physiotherapy, the Chartered Society of Physiotherapy (CSP). While practitioners predominately practise Western medical acupuncture as an adjunct to their primary conventional therapy, the AACP does not restrict itself to a biomedical description of practice. Although the majority of acupuncture provision in the NHS is of Western medical acupuncture rather than traditional acupuncture (Saks, 2005a), on the AACP website acupuncture is described as using both biomedical and traditional descriptions, pointing at an intriguing tension: on the one hand it adheres to the mainstream position of physiotherapy as an allied to medicine profession, and with it to biomedical explanatory models of acupuncture with an emphasis on Randomised Clinical Trials (RCTs) on acupuncture. At the same time, however, it appears that there is a genuine interest in the traditional, esoteric knowledge and the holistic philosophy of acupuncture.

Acupuncture is described by the AACP (2010) as a treatment ‘for inflammation and pain’ that is ‘evidence-based’, founded on ‘scientific evidence’. The mechanism of acupuncture is explained using biomedical explanatory models such as the release of natural pain-relieving chemicals as endorphins, melatonin and serotonin. However, intriguingly, the biomedical explanatory model of acupuncture is followed by a description of the ‘traditional’ Chinese medicine explanatory model, with reference to holism, the balancing of *qi*, balancing between *yin* and *yang*, and balancing the overall state of the body. So while biomedical notions receive precedence, traditional esoteric knowledge is not ignored and is not rejected. In fact, one leaflet from a physiotherapy centre in an NHS hospital, describes acupuncture to patients using only a traditional acupuncture explanation without inferring to the biomedical explanatory model at all. The following quotes are taken from the AACP website. Note the use of both biomedical and non biomedical descriptions, side by side:

> Acupuncture is one of the many skills used within physiotherapy as an integrated approach to the management of pain, inflammation and as a means of enhancing the body's own healing chemicals in order to aid recovery and enhance rehabilitation.
>
> Acupuncture forms part of traditional Chinese medicine (TCM). This ancient system of medicine dates back as far as 1000 years BC and is based on a holistic concept of treatment which regards ill health as a manifestation of imbalance in the body's energy.
>
> Re-establishing a correct balance is the aim of TCM. Energy is referred to as *qi*, (pronounced chee) and is described in terms of *Yin* energy – quiet and calm and *Yang* energy –vigorous and exciting. They are complementary opposites and in health exist in a dynamic but balanced state in the body.

According to Nicholls and Cheek (2006) physiotherapy, originating from massage, adopted a biomechanical model of physical rehabilitation to enable masseuses to view the body mechanically 'as a machine', rather than in a sensual sense. The medical patronage of the Society of Physiotherapy enabled physiotherapists to prosper amongst competing organisations. It established itself as a profession with high clinical legitimacy with an area of expertise (muscular-skeletal conditions) that involves non-pharmaceutical and non-invasive interventions. Currently physiotherapists are regulated by the Health Professions Council to which traditional acupuncturist aspire to be a part. The fact that physiotherapists adopted acupuncture, a non-biomedical technique, as part of their arsenal of therapeutic tools is intriguing. One would expect physiotherapists, as mainstream practitioners, to practise strictly according to the principles of Western medical acupuncture. But this is not exactly the case. AACP practitioners I met with, whilst giving precedence to it, do not commit themselves exclusively to medical acupuncture (or to traditional acupuncture), but rather consciously adopt a strategic approach of 'whatever suits their patients'. The practitioners leaned towards a biomedical description of acupuncture, but without rejecting the traditional, Chinese medicine theory. Their approach to treatment is generally very symptom-oriented rather than a 'whole person' treatment. However, despite their biomedical orientation and despite having to comply with significant time constraints, they remain attentive to the concepts of traditional acupuncture, and

they allow space for both biomedical and traditional descriptions. In this way, they allow patients to choose the description s/he is more comfortable with. Carol uses acupuncture as part of her practice in an NHS physiotherapy centre. Although emphasising the biomedical view, she describes acupuncture to her patients with reference to both traditional and medical theories:

> In terms of how the acupuncture works I usually do say to them [patients] that that it's been used in China for thousands of years and there is a theory of traditional medicine about meridian theory and the flow of *qi* around the body, and unblocking [*qi*] channels can help to improve pain and can help to improve dysfunction in the body. But in terms of how we use it in the Western world, we tend to look more at the science of acupuncture and say to them [patients] that part of acupuncture works like a pain-gate theory and it also releases chemicals in the body both in the brain and in the spinal cord.

Matt, like Carol, works in an NHS physiotherapy centre. He too gives both medical and traditional descriptions without preferring one over the other:

> I'll say to them [my patients] that actually we have lots of theories about why acupuncture works and some of those theories involve transmission of calcium irons within the acting myosin segments of the muscle and that some of those theories actually involve meridians and the movement of energy around the body … I try and emphasise that there's not necessarily any right or wrong answer. The Western medicine approach is one theory of how acupuncture works, and [the] Traditional Chinese medicine approach is another theory, and actually people will choose what generally best fits with their way of thinking.

Lauren, who works as a physiotherapist on a navy base, is practising medical acupuncture, but she describes how her colleague at the base, also a physiotherapist, often uses traditional acupuncture:

> Until now the people that were doing acupuncture around me, they were doing more [medical acupuncture], rather than traditional, which is how I was taught, whereas Emily, who has recently come into the department,

> does quite a lot of traditional acupuncture and does quite a lot of more sort of channel-based, meridian-based stuff.

Matt presents an interesting dilemma. Whilst, as a physiotherapist the application of Western acupuncture is natural to him, in his view, medical acupuncture lacks the systematic theoretical underpinning found in traditional acupuncture. Rather than applying the needles without a guiding theoretical strategy, he would have liked to follow theoretical principles that guide a broader therapeutic approach, in the same way that traditional acupuncture does:

> Using the Western medical [acupuncture] approach actually has very little guidance, or very little theory behind exactly what we are doing, apart from the very basic theory that we are stimulating the acting myosin element of the muscle and changing the movement of calcium or iron, stimulating the nerve fibres within the muscle etc. It's not that I don't agree with that, I think that's all a rational explanation, but I think that you need more than that in terms of trying to predict what the effect of any particular action is going to be. And I think that what the traditional Chinese medicine approach provides [is] a very long recorded history of predictions of what use of particular acupuncture-points is likely to provide. I think that Chinese medicine offers a lot more guidance.

Holism appears to be understood by the four AACP practitioners in my study in mainly two ways. First, physiological functions in the body are seen as interrelated so that, for example, pain can result from poor blood supply to the painful area as a result of a chronic muscle spasm that is a result of emotional stress. Second, body and mind are interrelated, although this notion seems to remain as a general recognition rather than embedded in practice. The influence of acupuncture on the mind, according to my AACP interviewees, seems to be restricted to reducing stress and to its relaxing effect, rather than the broader and more complex reference to the body, mind and spirit interrelations, as in traditional acupuncture. Nevertheless, it can be argued that certain styles of traditional acupuncture, such as TCM, also maintain the same level of 'limited' holistic engagement. Below are three examples from the AACP interviewees, demonstrating this approach to holism:

> Carol: A lot of our treatments in physiotherapy need to be holistic because if you're looking at pain mechanism, for example, then often there will be more than one pain mechanism going on at one time. There might be something mechanical going on, there might be something neurogenic going on, and there might be something affective in terms of the fact that the psycho-social model would always impact on the rate of healing, for example or how the patients deal with their dysfunction. And therefore all of those things amalgamated together will decide how that patient gets better in a way, how effective it is in getting better and then how long it takes.
>
> Shelley: I know that acupuncture makes people quite relaxed doesn't it? So a lot of people that are in pain and have got a joint problem get quite anxious and quite relaxed, so with acupuncture you also get the psychological component. It relaxes people; it helps them to sleep better.
>
> Lauren: I think it [acupuncture] does affect your sympathetic [nervous system], your feelings, and what have you, definitely. ... Biochemically we're similar, whereas emotionally we're not.

Many traditional acupuncturists will argue that this is not 'real acupuncture', but an 'ostracised' and medicalised version of it. Still, these practitioners adopted a strategic approach, using their mainstream professional position to include acupuncture as a significant part of their tool kit, and without rejecting its unscientific roots. The holistic narration of the four practitioners was far less ambitious than that of traditional acupuncturists, yet it sits well within the range of their day-to-day practices.

There are echoes in this data to the work of Cant et al. (2011) on the integration of CAM by nurses and midwives in an NHS hospital. Nurses and midwives occupied a marginal position in relation to medicine despite attempts to improve their professional status and market share by strengthening their occupational boundaries and through efforts to extend the scope of their practice (Macdonald, 1995; Witz, 1992). Midwives (in1902) and nurses (in 1919) have gained professional standing but being formally subordinated to orthodox medicine (Saks, 1999). Both professions remained accountable for the medical profession in a way that their scope of practice is determined and delegated by medicine (Cant et al., 2011). CAM, due to its individualised, holistic and participative approach, seems

to be an ideal territory to increase and develop nurses' and midwives' autonomous practice. Indeed, nursing traditionally showed interest in CAM practice and the Royal College of Nursing (2003) published guidelines on the integration of CAM into nursing. However, it seems that their efforts to integrate CAM into hospital settings had limited success (Cant et al., 2011). This is due to a number of factors, including the lack of institutional support, budgetary restrictions, and 'the boundaries of practice already set for nurses and midwives by the medical profession' (ibid, p. 535). This is further problematised by the uncertainty around risk of CAM interventions, the fragility of its evidence base, and the unsystematic nature of training and credentials. Therefore, in light of the position of CAM itself, nurses and midwives had to rely on their therapeutic territory and professionalism rather than on the status of CAM knowledge (ibid). At the same time, claiming positions of knowledge and trustworthiness deriving from their professional status and their medical knowledge, allows nurses and midwives to present themselves as best placed to mediate risks associated with CAM. While this afforded a degree of occupational closure, it did not lead to a collective effort to include CAM in nursing and midwifery practice. Moreover, it did not unsettle the existing professional boundaries and it did not significantly enhance nurses' and midwives' professional roles (ibid). CAM did, however, contribute to extend the repertoire of practice in areas that have been subordinated in recent years. Physiotherapy achieved a legally underwritten professional status in 1960, after a long and highly politicise struggle with biomedicine (Saks, 1999).

It seems that AACP physiotherapists too, found in CAM an opportunity to extend the scope of their practice, or at least to extend their repertoire of tools. The fact that they show curiosity towards traditional acupuncture philosophy, and the discussion of the scope of acupuncture in treating 'broader', non-pain, related conditions, points at a desire to increase the scope of practice. As described earlier, historically physiotherapists had to drop the 'soft', sensual elements of practice and adopt a more mechanistic model, using medical patronage to prosper amongst competing organisations (Nicholls and Cheek, 2006). Acupuncture offers them an opportunity to increase the scope of practice into 'well

being', and my participants made reference to relaxation, stress reduction and sleep improvement. Moreover, as one of the participants indicated, Chinese medicine philosophy offers a broader therapeutic view that is extending the current 'localistic' strategic approach in physiotherapy. The provision of acupuncture as part of the physiotherapy arsenal of therapeutic skills appears to be almost institutionalised with the establishment of the AACP, as a physiotherapists-exclusive association that is associated with the Chartered Society of Physiotherapy. The AACP publishes a professional journal and it is not uncommon to see maps of the acupuncture meridians in NHS physiotherapy centres, or to observe boxes of acupuncture needles in the treatment room.

At the same time, while a degree of integration of acupuncture into physiotherapy is taking place, it is clear that such integration remains limited and controlled by medical practice and by biomedical knowledge. Primarily, physiotherapists are trained in medical acupuncture, as a natural extension of their biomedical training, and it is clear that the four practitioners I interviewed give precedence to the biomedical explanatory model of acupuncture. Second, there is clear emphasis by the AACP, on its website and in its professional journal, on biomedical research and evidence-base. Possibly, the biomedical explanatory model and the fact that acupuncture is considered a more 'scientifically credible' CAM discipline, with a relatively high numbers of RCTs assessing its efficacy and its safety[33], contributed to what can be described as 'controlled integration' into physiotherapy practice. The specialist position of physiotherapists on musculo-skeletal conditions and rehabilitation links well with acupunctures' reputation in that area. This may be part of the explanation for the arguably more formal integration of acupuncture in physiotherapy, compared with that of other CAM in nursing and midwifery. Moreover, as in the case of nurses and midwives, practitioners are able to claim an expert position compared with 'lay' practitioners, based on their ability to manage acupuncture related risk, based on their medical knowledge and expert position related to musculo-skeletal conditions and rehabilitation, as well as their NHS status. However, it seems that, while extending the repertoire of their

[33] There are a significant number of journals focusing on EBM and RCTs on acupuncture, including *Acupuncture in Medicine* (by BMJ), *International Journal of Clinical Acupuncture*, *Medical Acupuncture* and others.

practice, AACP acupuncturists, like nurses and midwives practicing CAM, do not re-shape the professional boundaries of their practice, and it remains controlled and monitored by medicine – although this observation requires an extended study beyond the small sample in my research.

Finally, in relation to the data in this section, I would like to refer to the notion of 'pragmatic holism' that appeared on a number of occasions in this chapter. While their holistic narrative appears more restricted and restrained compared with those of CAM practitioners, and much more aligned with the medical model, AACP practitioners change the way that they present acupuncture to their patients according to their audience and according to the nature of the condition being treated. They offer their patients primarily a biomedical explanatory model of acupuncture, but if they sense that their patient is interested in the traditional acupuncture model and the concepts of *qi, yin* and *yang*, and meridians, they are happy to offer this description alongside, or instead of, the biomedical one. AACP practitioners do appear to be genuinely interested in traditional acupuncture, and while they use their biomedical orientation to demonstrate their credible societal status, they are happy to shift to a non biomedical description of acupuncture when their patients seem to look for it. By that they are able to attach a more holistic orientation to their practice.

In the next section, I return to the data gathered from NMQ acupuncturists and homeopaths to consider the data in relation to two of the most widely mentioned critiques of holism in CAM. First, increased interpretive authority of the practitioner, and second, increasing – rather than decreasing – the medicalisation of patients' day-to-day lives.

5.9 Increased interpretive authority of the practitioner and increased medicalisation of patients' lives

I will now return to explore the data in relation to the categories that I laid out at the beginning of the chapter (figure 7). One of the concerns raised by the literature discussing the holistic health movement is that of the increased interpretive authority of the practitioner (Baer et al., 1998; Goldstein, 1999; Lowenberg & Davis, 1994). The biographic nature of the interview in many CAM (Scott, 1998) may result in the practitioner gaining profound interpretive authority to 'make sense' of the patient's biography - a biography which includes intimate and emotional issues as well as routine life events. Moreover, the fluidity and the high degree of reliance on practitioners' intuition and personal interpretation, may contribute to increasing this interpretive authority. For example, in the case of homeopathy, Chatwin (2009) argues that, compared with an orthodox consultation, the nature of the classical homeopathy consultation process appears to allow the practitioner 'a far greater degree of freedom with which to adapt the structuring of tasks' (Chatwin, 2009, p. 168). Since both traditional acupuncture and classical homeopathy practice involve a degree of non-standardised skills and intuition, there is a question of how 'fluid' practice is and how far this interpretive freedom can or should go. Moreover, since acupuncturists and homeopaths often bring a wide range of emotional, psychological, as well as routine life events of patients into the medical encounter, the critics argue that there is a danger that they increase the medicalisation of people's lives.

Increased interpretive authority in acupuncture

According to the BAcC standards of practice (2009, p. 3), practitioners are expected to provide highly individualised diagnoses. Moreover, there is an expectation held by professional bodies and schools of traditional acupuncture and classical homeopathy to respect the subjectivity and interpretive authority of the practitioner. The BAcC, for example, regards 'the legitimacy of the use of metaphorical language in translation; a respect for subjectivity; and highly

individualised diagnosis' (ibid, p. 4) as basic features of acupuncture practice. It argues that:

> Acupuncturists partially make their diagnoses based on the subjective experience of their senses, through questioning, palpation, listening, observing, pulse taking and tongue diagnosis. They treat patients as 'subjects' able to relate their stories through the language of experience (British Acupuncture Council, 2009b, p. 4).

The fact that acupuncture practice is so diverse and that it offers the practitioner so many potential therapeutic avenues, leaves the practitioner with near endless options to choose from, which also leaves plenty of room for interpretation. Marilyn describes the highly individualised nature of traditional acupuncture:

> When I look at a human being I don't want to only see that he has a certain deficiency, I want to see a whole human being. This is the main part of what is holistic. The other part of what is holistic is that as a result of that, the person is completely individualised so that two people can come to me with the same headaches - and even if they come to me with the same Chinese syndrome of headache, I will treat each one of them differently.
>
> Because there are endless variations and permutations of what a human being is, so I want to use the systems I know and which is a culmination of everything I've ever learnt. I want to use also my senses and my intuition and I want to combine Stem and Branches.
>
> I would also like to combine energy, but we're then talking also about 120 different combinations … so if I use all of that I can get countless possibilities and only one will fit this individual. So the chance that this would fit another individual is one in a million! ... Also there are 400 acupuncture points - how do you translate this? ... It's a combination of theories and it's a combination of observations

Marilyn's account demonstrates the complexity of acupuncture theory and of the expert knowledge and the degree of reliance on the interpretive qualities of the individual practitioner. However, several practitioners expressed concern that certain styles of practice are too complex and are relying too much on 'subjective' skills of the practitioner. Similar concern was expressed by Chris in relation to the Five Elements style of practice. Five Elements acupuncture focuses on the unique manifestation of *qi*-imbalance in the individual patient. Here the five natural

elements, fire, earth, metal, water, and wood, are differently reflected in each individual person, presenting a different energetic balance/imbalance in each patient. This also involves the observation of certain mental and emotional characteristics which are part of the analysis. The process of diagnosis requires a great deal of intuition and experience, as described by Chris, who is trained in both classical homeopathy and traditional acupuncture:

> I felt a lot of it [Five Elements training] was quite subjective, much more so than on the homeopathy course. And I found that quite unsettling and a bit worrying.
>
> I was quite uncomfortable with some of the approaches in Five Elements acupuncture training - that I was expected to use to try and figure out which element they [patients] were. So, for example, we were supposed to ask non-specific questions in a way of the 'Five Elements' acupuncture approach, but use certain tone or manner to ask a question. So if I was trying to test for 'anger', I would use a slightly more confrontational approach with the person to see what their reaction is.
>
> In some ways I felt that the skill is too highly tuned, again, too subjective to try and interpret somebody's particular reaction. You know, for example, we'd be looking at their facial expression on a single moment at a given time … Very difficult. And I thought it's just getting a little bit too difficult to interpret to be accurate.

Chris's unease with this style of practice is a matter of personal affinity of the practitioner with a certain style, possibly a result of his own personality and worldview. It is clear that he is more comfortable with a more remedial, less 'fluid' approach to practice such as TCM. Ann expressed her concern with what she perceives as the 'overly-subjective' nature of the Stems and Branches style of practice:

> It is a bit like astrology. If somebody says, 'I'm a Leo', if you know the basics [of astrology] you'd go 'Leo, yes! You are like [this or that]!', and sort of categorise people. ... If I know that somebody is 'colon in metal', [then I think] 'oh, in that case I know what you're like!'

On several occasions I encountered discussions over the highly attuned and highly intuitive nature of traditional acupuncture. Whilst I did not sense an overt 'over-intrusiveness' by acupuncture interviewees in relation to their patients' lives,

or a tendency to present their patients with overarching interpretations and recommendations in relation to their private and emotional lives, it is important to consider such unintended tendency as inherent in an 'individualised' medical encounter. I will return to discuss this matter at the end of this section, after discussing increased interpretive authority in homeopathy.

Increased interpretive authority in homeopathy

During my interviews with homeopaths I came across a large number of examples of this increased interpretive authority over patients' private and emotional lives. It is possible that this may be linked to the nature of the homeopathic interview. During the interview (often referred to as 'case taking') the practitioner looks for any changes that occur in the patient's life, including on emotional, mental and even moral levels (Fulder, 1996, p. 202). Practising for nearly 30 years, Helen is passionate about homeopathy. She describes it as a journey to 'enlightenment' during which she escorts patients through life changing experiences. Surely, such an intense medical encounter is emotionally charged and is complicated to manage, placing a great deal of responsibility on the practitioner's shoulders:

> Successful homeopathic consultation is about getting results and having patients transforming their lives. Not just even eliminating physical symptoms or maybe mental-emotional symptoms. It's about changing consciousness. That is what I always do from the beginning.
>
> The thrill I got out of it was the consciousness-saving aspect that many patients go through once they start to take the treatment. I mean this might sound strange and it might sound negative, but I cannot tell you how many women have left their partners, and said: 'I would never have done it without homeopathy'.
>
> Once you are on that journey, and it's [homeopathy] a journey, it's not even a one-off that you start to see things in a different way. Homeopathy is about enlightenment.

It is clear from my practitioners' narratives that they are often engaged with complex emotional and psychological concerns of their patients as part of their

quest to find the constitutional remedy[34]. For example, Phil's patient initially came to see him due to the epileptic seizures she suffered. However, when talking about the impact that the homeopathic treatment had on his patient, Phil extends the influence of his homeopathic treatment to the complex relationships that his patient had with her mother:

> She hadn't had any more fits, she felt fine. Every time I saw her she felt in the best of health and one of the biggest shifts she had was that she had a lot of problems with her mother, from childhood. Her mother had abandoned her as a child and she was passed back and forth between both parents and she was the eldest so she ended up looking after her little sister. Even when she left home she had to take her little sister in at one stage, to look after her, so there was this mother-abandonment issue which is something else that we did some work with alongside of what I was doing. So there was an understanding between mother and daughter which hadn't been there previously, so hopefully I had some input into that.

Martyn's description of his approach to homeopathy demonstrates the blurred borders between practising homeopathy and taking on other professional responsibilities such as counselling or psychotherapy. In fact he implicitly describes his approach as 'homeo-psychotherapy':

> I always say 'looking at what you presented with your symptoms today and what you've talked about in terms of your personality, and some of your history, and some of the factors in your life, you seem to be this kind of person'. And I offer them that, and I say 'Does this resonate with you? Does this mean something to you or am I completely off track?' So in a way I do what Sankaran does, in a way, he calls it homeo-psychotherapy.

Martyn then continues to describe the application of homeo-psychotherapy with an example from his practice. This case shows how Martyn uses a rather loose diagnostic procedure that completely relies on his intuition and his interpretive authority as a practitioner and on his own subjective interpretation of his patient's behaviour:

[34] A homeopathic remedy which matches the individual patient with her/his unique constitution and individual biography.

> A young man, the mum brought him, with autism spectrum, ADHD[35] and he certainly wasn't into communicating with me particularly. He was into playing with his gadgets and he got bored with that and I said 'Do you like drawing?' and he said 'Colouring'. I said 'Sure'. I opened my drawer and I pulled out this pad of white paper, I'd got some crayons here, and I said 'Okay, I'd love if you draw me a picture' and he did. He actually drew me a house and he put the windows in and the doors. The second time he did a register and the register was important- it was a school register. And he'd separate the lines, he'd draw dotted lines one under the other and he'd start putting numbers in them. He started to highlight certain lines, so for him this was a meaningful activity and for me it gave me an insight into his need for order. I understood that this youngster needed order. So perhaps he needed a mineral remedy [mineral remedies in homeopathy are often linked with being organised]. I gave him Barita carbonica which is a mineral remedy and it worked really well. He became less anxious about ordering everything, you know, more relaxed.

Such an approach to practice cannot be standardised and Martyn was not following any routine, standard procedure in his search for the homeopathic remedy. It seems very unlikely that another practitioner would have made the same set of observations and interpretations as Martyn did in this particular case. The following quote in which Louise describes a case from her practice is another example of the indeterminate nature of homeopathic prescribing. She is shifting between a carefully structured, systematic prescribing, to a complete reliance on her intuition. Like Martyn in the previous case, Louise is also relies on her interpretive authority in her quest to prescribe the most suitable remedy:

> I had the strangest experience the other day where a little boy, who was autistic, he has got this thing about balance, like *yin* and *yang*, he can't make decisions. Like it would mean he had to exclude one thing or another. He must walk down the middle of an aisle, all sorts of fascinating things and he was really, really stressed out whenever there's no balance.
>
> The only thing he really said to me was that he wished he could have a time machine so that he could come back. He didn't want to answer any questions because he had to make a decision, but he told me he wanted to come back in a space machine or have a space machine so that he could go back to the time when the dinosaurs were here and find out the real reason why they were extinct.
>
> So I thought that was interesting. I looked at the periodic table [many homeopathic remedies are made of elements in the periodic table] about which I knew very little of and I'm thinking 'I really do need to study this'. I

[35] Attention deficit hyperactivity disorder.

> thought, 'Well let's go for something in the middle [of the table] here' because he wants balance, and he's very interested in elements and symbols and things.
>
> So I thought 'Well that's the kind of mind he's got maybe I'll try and have that sort of mind', and I looked in the middle and near the middle was Iridium, which is a remedy I don't know. And I looked up the remedy and it said: 'This is thought to have been responsible for the extinction of the dinosaurs', and I was amazed. And that to me was sort of like a key. And then when I looked at the remedy picture all sorts of other issues fitted the case.

In contrast, while such examples were common, some practitioners, like Penny, the homeopathy school principal, expressed concern with the degree of interpretive authority of the practitioner in the homeopathic consultation. Penny describes how during the homeopathic consultation she tries to resolve this concern by defining the borders of her interpretive authority at the beginning of the homeopathic interview:

> When I begin a consultation with somebody who knows nothing about homeopathy, which is often the case, I will say that there are three things I don't do. They are: I do not diagnose you from a conventional point of view although I'm well trained and I'm really interested in what the 'plumbing' is doing and what the 'electricity' [does], but I will draw different conclusions than your GP. Secondly, I don't interpret anything you say. I'm not sitting here thinking 'Clearly when you had that trauma when you were four year old this has led to your mother or your Oedipus complex' or whatever. I'm not interested in that kind of interpretation.
>
> I'm not interpreting your dreams; I'm not interpreting your actions. And thirdly I'm not judging you. I'm not your moral superior. Sometimes you can see their shoulders go 'Oh thank god for that' you know. I say I have all the vices. I'm a frail human being just like you. And together we'll form a team and I'll be one of many people who can help you.

A similar approach to Penny's is taken by Ruth who is determined to make it clear to her patients that although homeopathy requires attention to the patient's personal and emotional biography, it does not involve analysing or advising on such issues, but merely identifying and prescribing the suitable homeopathic remedy:

> I'm not a counsellor. I'm not digging around for stuff. I'm not saying necessarily that counsellors do [dig for stuff] but what comes up is what the patient chooses to come up with and it's just there, I just let it be. I don't control it, I don't take action. I know it sounds harsh but I do not actually do anything other than give the medicine. I can hear how harsh that sounds but I'm just here to give the remedy.
>
> Different homeopaths seem to have different sorts of practices and attract different types of people. It would seem that people that come to me have a lot of emotional stuff to say, but I don't feel it is my place to make any judgement on what they're saying, or give them advise on what they're saying, or negate what they're saying.

This seems to be an area of concern for some of the study participants who are trying to place boundaries around the scope of their practice. Still, considering the nature of the intimate issues that are often discussed in the course of the homeopathic consultation, arguably such efforts are limited and increased interpretive authority is unavoidable. Even if the practitioner 'delegates' acting upon sensitive emotional and psychological issues to the action of the remedy, surely dramatic changes (such as the ones described in my participants' narratives) may lead to an emotional stir, and may require emotional support from the practitioner.

The concern of 'victim-blaming' and placing responsibility over health on individuals

A number of sociological accounts point to the way that biomedicine and health authorities often place the blame for diseases caused by broader social structures on patients themselves, what is described in the literature as 'victim-blaming'. For example, patients are held responsible for their unhealthy behaviour and for being obese, for smoking, or for eating unhealthy food. Paradoxically, despite being part of the medical counterculture and part of the critique of biomedicine, many CAM seem to place a similar focus on individual responsibility (Goldstein, 2003, 1999). On several occasions during practitioners' narratives, a 'personal responsibility' approach did surface in the data. For example Lucy suggested that some people do not want to heal (and will not heal as a result) because they have a 'vested

interest' in their illness, very much in line with the bestseller *You Can Heal Yourself*' by Louise Hay, which I discussed in Chapter Two:

> I think that it's the persons themselves that will heal, and the acupuncture is the facility to do that process rather than you know, performing magic with needles. Because I think if people don't want to heal, if they've got a vested interest in their illness, then they won't heal.

In their discussion of the dual discourse of medicalisation-demedicalisation in the holistic health movement, Lowenberg and Davis (1994) emphasise a number of claimed demedicalisation-related characteristics in holistic health: 1) in direct opposition to the allopathic medical model, the placing of emphasis on patients assuming responsibility over their own health through information seeking, dietary monitoring, stress reduction, spiritual exploration and behaviour modification, 2) by encouraging greater patient involvement in the medical encounter practitioners reduce the social distance between practitioners and their clients, encouraging a more egalitarian practitioner-patient exchange, and 3) they increase the medical concern from symptomatic focus to broader concerns including psychological and spiritual dimensions. Lowenberg and Davis point at a number of contradictions in relation to each of the aforementioned points. As discussed by a number of authors cited in Chapter Two (for example Coward, 1989), the focus on individuals and encouraging participation and responsibility through the 'empowering' of patients, may result in an unintended paradox whereby patients develop feelings of guilt and shame. While I encountered very few examples of practitioners implicitly suggesting that patients are 'responsible for being ill' or 'are responsible for getting better' (as in Lucy's quote), such medicalisation process might be subtly, paradoxically, and unintentionally, embedded in a medical encounter that encourages patient involvement and responsibility in relation to the healing process (i.e. recommendations such as to eat certain foods, de-stress, exercise, take herbal remedies and vitamins, 'or else'). Moreover, I would argue that the problem of 'increased interpretive authority' in acupuncture, and even more so in homeopathy, broadens the pathogenic sphere and hence increases the conflict between the effort to demedicalise and medicalisation in practice. It tends to bring 'day to day' events, and sensitive, intimate emotional matters, into the medical encounter. The dimension of a more democratic patient-practitioner

relationship, and reducing the social distance between them, will be discussed in section 5.10.

In light of these potential difficulties in the holistic discourse, practitioners' reflectivity in relation to such sensitive matters is an essential consideration in practice. In the following section I will briefly discuss the notion of reflectivity and consider practitioners reflectivity in relation to what can be described as 'holistic tensions', i.e. potential sensitivities in relation to the holistic ethos of the therapies and the medical encounter that is part of it.

Practitioners' reflectivity in relation to 'holistic tensions' in their practice

At this point, in light of the discussion of practitioners' degree of interpretive authority in the medical encounter and the debate over medicalisation-demedicalisation, I would like to discuss the importance of practitioners' reflectivity in relation to their holistic discourse and practice. Following her ethnographic research on CAM education, Gale argues that the vulnerability of patients and 'the potential for physical, psychological and emotional invasiveness make a clear case for the importance of a reflexive awareness of power and interaction in the therapeutic relationship' (Gale, 2009, p.19). She suggests that

> For student-practitioners, a reflective grasp of that power-imbued relationship is (or should be) an essential component in professional education. Appropriate educational tools for this may include critical discussion of the concept of partnership and other models of interaction (Gale, 2009, p.20).

Reflectivity is a key component of professional education and practice in health and social care, and is adopted in professional education as an essential part of practitioner's professional development (Karban & Smith, 2006). Reflective practice relates to knowledge generation processes and the importance of attending to both rational and irrational responses to learning and practice encounters (Rugh, 2010). Donald Schön (1983) discussed the concepts of

reflection-in-action and reflection-on-action as central to professional's work. Reflection-*in*-action involves the consideration of our experiences, how we feel in relation to our experiences, and attending to our theories in use. The concept reflection-*on*-action is reflecting after an encounter in practice took place, which enables practitioners to explore their actions by developing questions and ideas over their practice in a way which allows the practitioner to engage with situations in practice. A number of scholars discussed *critical reflection* as advancing the reflection process and questioning experiences within a broad context of issues (Murray & Kujundzic, 2005). Brookfield (1988) described critical reflection as reflecting in a manner which challenges our beliefs, values and social structures and which involves contextual awareness to specific historical and cultural contexts. Moreover, he recommends that during the reflective process practitioners develop a 'reflective scepticism' in relation unexamined patterns of interaction in practice.

The discussion of the holistic discourse that was presented in Chapter Two demonstrated the way that this discourse in CAM is dynamic in nature, influenced by historical, political and societal forces and actors. Exploring NMQ acupuncturists' and homeopaths' reflectivity in relation to their holistic discourse helps examine the strategies that they use and the way that they negotiate this discourse in the process of formalising education. Moreover, as mentioned, reflectivity in relation to one's knowledge and practice is recognised as an important part of professional, formalised education in health and social care. In its *Standards of Education and Practice,* the Health Professions Council guides regulated health professions to ensure that the taught curriculum ensures that 'the delivery of the programme must assist autonomous and reflective thinking' (Health Professions Council, 2005, p. 5). While, during their professionalisation efforts, BAcC and SoH aspire to belong to the HPC as regulated health and care professions, the process of formalising education might include an emphasis on reflective practice and possibly deeper, critical reflectivity in relation to own practice (British Acupuncture Council, 2011; Society of Homeopaths Education Department, 2009). For example, in its *Aiming for Excellence: Homeopathy and Higher Education*, it is suggested that on completion of an accredited course, homeopaths should be

> Able to reflect on their practice utilising critically the dynamic and complex body of homeopathic knowledge [my emphasis], challenging their skills and continually seeking to develop their expertise as a practitioner (Society of Homeopaths Education Department, 2009, p.3).

It is evident from the data in this section that some practitioners are more engaged in reflectivity than others in relation to the degree of interpretation that they maintain over their patients' lives as part of the medical encounter. So far, I have discussed holistic concepts in the context of wider self. I will now turn to discuss holistic concepts in the context of wider world, to discuss the nature of the medical encounter, and the holistic claim for an empathic, empowering medical encounter in acupuncture and homeopathy.

5.10 Personable, attentive, democratic medical encounter, and shifting the focus from the practitioner to the patient

One of the most important aspects of acupuncture and homeopathy practice, very commonly discussed by the study participants, was establishing good rapport with the patient. More precisely this entails being attentive to the patient's point of view, allowing the patient the space to express their feelings and views comfortably, establishing an atmosphere of trust, and ensuring that they are not treated as commodities. In short, a more egalitarian relationship between the practitioner and the patient, allowing the patient the opportunity to be involved in shaping the therapeutic relationships and the therapeutic strategy resulting from it, is seen as important. As Chatwin points out, much of the appeal of CAM appears to be grounded in the perception that the patient-practitioner interaction 'will somehow embody interactional elements that have become attenuated or lost in conventional medical encounters' (Chatwin, 2009, p. 164). Many argue that such discourse does not always take place in CAM, and that at times conventional doctors spend more time listening to their patients than many CAM practitioners do (ibid). In fact, while I was in practice, on numerous occasions I encountered acupuncturists who spoke very few words with their patients. Yet, as Gale (2009) points out, it is often assumed that CAM practice provides an ideal site for the

delivery of patient-centred care and empowerment of patients. The following section is a short summary of notes taken during a day-long participant observation in Lucy's acupuncture practice. This observation was valuable in that it afforded me the chance to witness Lucy's attentiveness to her patients' points of view, and the sensitive and delicate manner in which Lucy negotiates her patients' needs as part of her clinical approach.

Participant observation: Lucy's acupuncture practice

Lucy's practice is situated in a seaside town, not far from the seafront. It is a physiotherapy clinic that is shared by several practitioners, including several CAM practitioners. While in practice, Lucy wears a white coat. The treatment room is rather small but bright and comfortable. It is mainly occupied by a hydraulic bed. On the book cabinet there are several professional books, and essential acupuncture accessories, including disposable acupuncture needles, antiseptic liquid, cotton balls, moxa, and glass cups. The first patient of the day is Meera (pseudonym), an older woman who arrives with her daughter. Meera is a wheelchair user. Lucy welcomes her into the waiting room. Meera describes how two years ago, following the death of her husband, she suffered a stroke. She talks about his death. She describes how it all happened 'all at once'. Lucy is sympathetic, listening, not rushing Meera, allowing her space to tell her story. Lucy then asks questions, systematically exploring the different body systems, eating habits, emotional issues and 'energy levels'. Meera has allergies that involve irritation to her head and ears which cause itching which then disturbs her sleep. Meera says that eating certain food, such as meat, causes her depression. Lucy listens and writes the information on the patient's chart. For quite a long period the focus of the discussion is Meera's diet. Lucy asks Meera to rate her energy level on a scale from one to ten. 'Not great. Six at the most', Meera replies.

Lucy would like to know what, from Meera's point of view, should be the focus of the treatment. 'The pain in my leg and then the itching in my ears'. Lucy looks closely at the patient's leg, trying to learn more about the problem. She then

explains the treatment procedure that she is about to follow. She looks at Meera's tongue and takes her pulses in both hands. She takes the pulses again. She explains that she is looking for certain qualities of the pulses. She takes another look at Meera's tongue. Lucy then takes a couple of minutes for herself, thinking. 'Have you ever had acupuncture treatment before?' 'No but I had acupressure once'. Lucy then washes her hands. 'Would you like me to put on relaxing music?' 'No need'. Lucy explains about the needles while tapping the first one under the skin. 'How was that?' 'Sharp pain'. Lucy manipulates the needle, looking for 'tingly' or 'dull' sensations. 'How is that?' 'Slight pain. But it's gone now'. Lucy taps in another needle. She swivels the needle. 'How is it? Painful? Sharp?' 'This one was painful. But it's gone off now … I feel sleepy' Meera says. 'You wouldn't think having needles stuck in you makes you feel quite relaxed' says Lucy. She taps in one needle in the forehead. 'Not much flesh in there' is it Meera says jokingly. She seems very comfortable. 'No, but it has to go in. … these [points] are fantastic for allergies'. 'I will leave you to relax for 5-10 minutes. I am right behind the door'. Lucy dims the lights, checks the pulses again, puts on relaxing music, and covers Meera's feet with a towel. Seaside sounds come out of the speakers and we walk out. Within a short period of time, with her careful yet not overbearing attentiveness to Meera's needs, Lucy established a personable, comfortable rapport with Meera. Very quickly Lucy dissolved any tension that Meera may have had about being treated with acupuncture and putting her health in the hands of a practitioner that she had never seen before. It was evident that, as the session progressed, Meera became more talkative, and was more comfortable sharing personal information with Lucy. By the end of the first acupuncture session it felt as if that the two had met several times before. I will now return to the interview data to continue the discussion over holism in the context of the medical encounter.

Like Lucy, Nicola tries to encourage her patients to feel part of the healing process. At the same time, in order to ensure that the focus in this clinical encounter is on the patient rather than the practitioner, she downplays her role in the healing process:

> I try to play no role. I try to have as little influence on my patients mentally. I don't want them to become dependent on me. I want them to feel that they

> were very much part of their healing process. So it's not me who has done something, it's not acupuncture that has done something; they have managed to do it themselves.
>
> I try always very much to stay in the background of the process. I think there's nothing worse than feeling ill and not being in control of how you feel, and it must be terrible. I am lucky that I'm healthy, but it must be terrible and all I can be is a friendly listener really, and try to help them physically to get better.

Again, it is possible that the kind of rapport established in the medical encounter is informed by the style of practice, as some styles of practice require more attentiveness to the patient's biography than others. For example, classical homeopathy often requires longer, more personal and in-depth case taking than complex or combinations homeopathy. It is also important to bear in mind that CAM practitioners compete in the private market; this puts them under pressure to maximise their profit, which may result in compromising their rapport with their patients. For example, a well-known classical homeopath offers online or phone consultations. On his website he offers effective homeopathic advice at the patient's own home. Also, Mick, who has practised homeopathy for 22 years, offers telephone appointments on his website. I asked him whether it compromises his rapport with his patients. After all, if rapport is such an important aspect of holistic practice, how does 'distance-homeopathy' coincide with this holistic notion?

> I much prefer - even if it's somebody who has a sore throat, come in and see me. And the results are better because it's much easier to establish a rapport when you can see them. You can see what state they're in and whatever else goes on between people when they're present together.

Returning to Lowenberg and Davis's (1994) discussion on medicalisation-demedicalisation in holistic health, it seems that of the three analytical dimensions that I discussed in section 5.9 - increasing the scope of the medical concern from symptomatic focus to broader 'constitutional' concerns, encouraging greater patient responsibility and involvement in the medical encounter, and reducing the social distance between practitioners and their clients - the latter dimension is where demedicalisation is most successful. Indeed, this is reflected in some of the data in my research, including the two practice observations with 'Lucy' and with

'Martyn', and in the awareness of this element of practice in practitioners' narratives. Nevertheless, as Lowenberg and Davis argue, in holistic health, this medical encounter moves in both directions of medicalisation and demedicalisation:

> The three analytical dimensions proceed in opposing directions, so that there is no unilateral movement in the direction of *either* medicalisation or demedicalisation [emphasis in original]. The locus of causality is restored to the responsible self, thus denying patients absolution from responsibility for their illnesses. The status differential between providers and clients is minimised, resulting in a more egalitarian exchange and at least partial symmetry within interactions. Thus holistic health represents demedicalisation activity in both those dimensions. Simultaneously, the exponential growth of the pathogenic realm clearly portends a thrust toward still further medicalisation (Lowenberg & Davis, 1994, p.594).

Moreover, in discussing the patient-practitioner partnership, Gale (2009) discusses some important questions of power relations in that relationship. The partnership model and promoting the empowerment of patients challenges the asymmetric power relationship between the doctor and the patient, and, as discussed in Chapter Two, it is often argued that CAM facilitates such empowerment. There are however a number of challenges to the implementation of the partnership model: the patients in this partnership often have much more to lose than the practitioner; and the practitioner has access to specialised knowledge and concepts, such as medical terminology and theoretical concepts as 'vital force' (homeopathy) and *qi* (acupuncture), which are not 'visible' or understood to patients when consenting to treatment (ibid). Moreover, as discussed by Lowenberg and Davis (1994) and by Coward (1989), this model of 'joint responsibility' might lead to 'victim blaming' and the placing of responsibility for ailments on the patients themselves. Importantly, such challenges to the nature of the medical encounter in acupuncture and homeopathy require significant degree of awareness by the practitioner, and a reflective discussion in relation to the nature of their holistic discourse.

5.11 Practitioners' concern with the broad environment of patients

Sociological accounts debate whether, considering the critique those CAM practitioners and their users present in relation to biomedicine and the medical

establishment, CAM may be considered to be part of a larger social movement (Goldstein, 1999; Schneirov & Geczik, 2002). Against this argument several accounts pointed out that along with its focus on the individual, CAM shows little concern with the broader sociocultural and geopolitical environments of patients and their impact on health (Baer, 2003; Baer et al., 1998; Lowenberg & Davis, 1994; Salkeld, 2005). Indeed, most practitioners in my study showed little awareness or engagement with the broader environment of their patients. This was evident in both practitioners' narratives as well as on their websites, but it was also apparent in acupuncture and homeopathy education. Linked with the concern over CAM's lack of engagement with the broader environment of patients is the fact that for many, acupuncture and homeopathy are not affordable and, hence, not accessible to many. Since both acupuncture and homeopathy, like most CAM, are practised mainly in the private market, they are accessible only to those who can afford them. Homeopathy has been particularly closely linked with the social elite and has been criticised for being an 'elitist' profession (Morell, 1998). However, acupuncture, too, is an expensive commodity in Western countries that many people cannot afford. In contrast to the lack of awareness of the influence of the broad environment on health, the lack of access to homeopathy by people with few financial means clearly bothered some of the homeopaths I interviewed. For example Ann, Martyn, Louise and Penny all practice in low cost clinics or charities, offering treatments at reduced cost for people who cannot afford their normal fees. Louise works at a centre which describes itself on its website as made up of

> Therapists who are interested in promoting the use of holistic therapies through subsidised treatments for children with learning difficulties [rephrased].

The fee is significantly reduced compared with normal fees for a homeopathic consultation. Other than these examples of practitioners' effort to increase access to homeopathy, awareness of broader societal concerns was restricted to that of the critique of practitioners in relation to biomedicine and the pharmaceutical companies as 'oppressive' and 'aggressive'. During the interviews, when the impact of the broader environment of patients was not discussed, I eventually asked practitioners whether the influence of socio-cultural and geo-political concerns is something that they consider as part of the medical encounter. Most

practitioners seemed surprised by the question, and it seems that this concern was not something that they were aware of. Take Andy for example:

> I don't think it [the social and cultural environment of the patient] is something I've ever considered. Really, I don't know why ... I mean, we're supposed to live in a multicultural society aren't we, and so is it that relevant? I don't think I can answer your question because I've never considered it. It is not something that has really ever been on my radar.

In homeopathy, there is a certain consideration for the influence of social or environmental dynamics in relation to the patient's health; these dynamics are described as 'maintaining causes' (Gale, 2007, p. 214), which are factors contributing to the perpetuation of a certain problem (for example a patient suffering from asthma is a heavy smoker which constantly contributes to the asthmatic condition). But I could not find evidence in practitioners' narratives for a discussion of the factors, or the health determinants that influence such maintaining causes (for example the social, economic or cultural factors contributing to smoking), or how such causes should be addressed. It should be noted that in contrast to practitioners' lack of awareness, both the SoH and the BAcC do make implicit reference to the importance of social, cultural and economic environments of patients. The SoH *Clinical Education Guidelines* specifically state as part of the practitioner's 'Commitment to Professional Principles and Values' that:

> Practitioners can demonstrate: … a reflective awareness of the individual and their familial, social, spiritual, cultural and economic context (Society of Homeopaths, 2010, p. 16)

In acupuncture, too, the *Guideline for Acupuncture Education*, published by the BAcC, makes clear reference to the need to develop students' awareness of issues that are part of wider world holism, including environmental and socio-economic issues (British Acupuncture Council, 2000, p. 9). I will discuss this matter further in the next empirical chapters, but I found very little evidence of this awareness in practitioners' narratives. In fact, it seems that by referring to the social environment of the patient, practitioners refer only to the impact of the social encounter with people in their immediate environment (such as family,

school, work) and its impact on their feelings and mental state (grief, anger, etc.), rather than the impact of broader societal, political, economic or cultural circumstances. Overall, I would describe practitioners' attitudes to the broad environment of patients as a lack of awareness but not as a lack of care for the matter. When I prompted a discussion about the broad environment of patients, in most cases, practitioners were unable to place this issue in the context of their own practice, but did recognise the importance of it.

It is possible that the fact that most CAM is practised in the private market (Hunt et al., 2010), may leave many practitioners working in a certain professional isolation from the public healthcare sector, which may contribute to this lack of awareness. The characteristics of both CAM practitioners and CAM users seem to point at significant forms of geographic and socio economic stratifications (Cant, 2009), and this may well be linked with a certain detachment from broader public health concerns that I encountered in practitioners' narratives. Surveys suggest that CAM users are more likely to be middle class (Thomas & Coleman, 2004) and as Cant (2009) points out, the location of CAM practitioners in middle-class areas with middle-class demographic features, suggests important spatial differences and geographical inequalities in both provision and utilisation of CAM (Cant, 2009). Therefore this limited awareness to matters such as social exclusion, socioeconomic status, ethnicity, living conditions, education, and their impact on populations' health, is perhaps not that surprising.

I will now continue to examine the final category in this chapter, which poses a certain paradox in the therapies' holistic discourse. Quite often acupuncturists and homeopaths support unscientific claims that are part of their practice, by using scientific concepts and by relying on the credible societal status of biomedicine.

5.12 Relying on the reputation of biomedicine to support holistic claims

The representation of CAM as an anti-oppressive, anti-reductionist alternative to biomedicine brings about some intriguing dilemmas in relation to its emergence in

the West. The majority of acupuncture and homeopathy practitioners and consumers in the West are surrounded by a scientific, rational worldview. Surely, despite its critique, the dominant position of the medical profession, of science and of 'reductionist thought' must have influenced views and attitudes of CAM consumers and practitioners alike. During the research I often came across the adoption of biomedical narratives by my participants to support the representation of holistic claims. Moreover, in light of the superior position of biomedicine in society, biomedical terminology was often used to boost the credibility of practice. I will now present several examples from the data.

On his website, Mick, who was trained at the school of the renowned Greek homeopath George Vithoulkas, presents homeopathy as the 'deepest' and 'most gentle' stimulation possible of the immune system. He describes the way that the body at times operates an 'unsuitable immune response, or as he describes it, runs 'the wrong programme' for the immune system. This 'wrong' immune response, it is argued, leads to a pattern of recurring medical conditions such as asthma or eczema. Homeopathy, he suggests, provides the immune system with the 'correct information' so that it can generate better 'immune response'. The 'immune system' is a term that is used in relation to a comprehensively described biological system which is based on scrupulous biomedical inquiry. Using it next to such claims about homeopathy suggests that the way homeopathy works fits in with the scientific description of that system. Possibly, Mick used this description of homeopathy and the immune system to support the holistic claim of encouraging the body's natural healing forces. In any case, using metaphoric language such as 'runs the wrong program', 'run old programs', or that homeopathy 'give[s] the body the correct information', appears speculative, and does not suit the precise nature of scientific inquiry. Furthermore, this focus on the immune system in isolation seems to contradict the argument that homeopathy looks at the patient while considering the interrelations between body, mind, and spirit.

Another example of the way biomedical terms are used to enhance non biomedical terms is the way Nicola uses the biomedical term 'homeostasis' to

describe the way acupuncture works. On her website, she describes acupuncture's ability to restore and maintain health, and promote a state of homeostasis, by stimulating the person's own healing forces. The term homeostasis refers to the tendency of an organism to regulate its internal conditions regardless of its outside conditions, and thus maintain equilibrium within its internal environment (temperature, ph, etc.). Although it is often used metaphorically in social sciences, here Nicola the practitioner uses the term in relation to body functions, arguing that acupuncture 'catalyses homeostasis by stimulating the self-healing powers of the body'. Again, the biomedical term is employed to support the holistic claim for acupuncture's ability to enhance the innate healing capacities of patients.

The difficulty arises when practitioners rely on the reputation of biomedicine while amending biomedical concepts to support holistic claims, what Montgomery described as 'symbolic adaptation' (Montgomery, 1993, p. 78). This is particularly problematic if such use in biomedicine follows anti-reductionist rhetoric, as it may suggest a certain paradox in practitioners' claims. For example, Tara, on her website, it is argues that acupuncture often provides explanations for symptoms that biomedicine have no explanation for. As an example she discusses the way that, during a heart condition, patients often have pain radiating down the left arm to their little finger. She suggests that while conventional medicine does not have a clear explanation for this phenomenon, acupuncture theory can explain it through the location of the meridians and the energetic channel of the heart. At least in the case of pain radiating to the left during heart attack, biomedicine *does* provide biomedical rationale for the phenomenon[36]. The link made by Tara to support the validity of acupuncture's esoteric basis by drawing on a biomedical point of view is not quite accurate. I would like to further demonstrate this paradox

[36] The biomedical hypothesis is that nerves from the heart join with other organs from the general area, and follow the same nerve pathways to the spinal cord then to the brain. Along the way, surrounding neurons are stimulated which creates a sensation of generalized discomfort commonly interpreted as pressure or a dull ache to the generalized area, typically the left arm and neck.

by describing another practice observation, which took place at Martyn's homeopathic practice.

Incorporating scientific research into the holistic rhetoric: An observation at Martyn's practice

So far, on a number of occasions, I have mentioned the drive to increase evidence based practice/medicine (EBP/EBM) in CAM, including an implicit recommendation in the House Of Lords Select Committee (2000, sections 7.10-7.30), to use Randomised Clinical Trials (RCTs) in order to build 'an evidence base' on CAM. As pointed out by Timmermans and Mauck, 'it is difficult to exaggerate the resonance of EBM in contemporary healthcare' (2005, p. 19). EBM is defined as the continuous, explicit, and judicious use of current best evidence in making decisions about the care of individual patients (Sackett, Rosenberg, Gray, Haynes & Richardson, 1996). This is done through the application and the review of biomedical scientific research and using it to guide practice decisions. The supporters of EBM see the process of tying clinical practice with scientific standardisation of research evidence as a way of addressing 'unacceptable variability' in health care provision, as well as addressing the rising costs and prioritising interventions and practices (Timmermans & Mauck, 2005). Rather than relying on practitioners' accumulation of personal experiences for clinical effectiveness, supporters of EBM argue that clinical decisions should be based on objective research findings that are gathered according to scientific criteria. There is however, an accumulating critique towards the drive for EBM, commonly heard from within the medical professions (ibid). Such critique includes suggestions that the 'craft', the artistic nature of practice and of the individual practitioner are lost in this process, discouraging healthy individual innovation and competition between practitioners:

> Instead of revolutionising care EBP therefore threatens to bring about stagnation and bland uniformity, derogatorily characterised as "cookbook medicine". Ironically, EBM may also result in a lower standard of safety by

> deskilling practitioners. Instead of using clinical judgement, practitioners will be encouraged to follow protocols that treat all patients as essentially interchangeable' (Timmermans & Mauck, 2005, p. 21).

In line with this critique, it is not surprising that while rigorous RCTs are regarded as the 'gold standard' of EBM, many argue that RCTs are unable to capture the 'non-standardised' nature of CAM (for example Barry, 2006, p. 2648). This is because while often in CAM there is emphasis on individual patients as different from one another, RCTs attempt to minimise the presence of such differences. This conflict, Keshet (2009, p. 148) argues, results from the tension between reductionism and holism and the fact that while scientists and conventional doctors give precedence to reductionism, CAM practitioners give precedence to holism. Moreover, politically, Keshet suggests, while CAM practitioners use holism as a rhetoric or a strategy to gain popularity, biomedicine's discourse seeks to maintain a dominant position by establishing an epistemic authority, for example by giving precedence to biomedical research (ibid). Nevertheless, despite this critique of RCT's and of the drive to increase emphasis on biomedical scientific research, I found that professional bodies, schools and practitioners of both therapies make frequent use of such clinical evidence to boost the profile of their practice. On its website, the BAcC suggests that a:

> Growing body of evidence-based clinical research shows that traditional acupuncture safely treats a wide range of common health problems (British Acupuncture Council, n.d.).

The SoH also calls for increasing the research evidence base while suggesting that clinical research appears to support homeopathy as a safe and effective approach. In fact, most of the study participants made reference to scientific research, on their websites, in order to provide their practice with 'scientific credibility'. In the following section, I would like to present an observation of homeopathy practice, demonstrating the way that Martyn, whilst in practice, makes frequent reference to clinical research in order to boost the credibility of his recommendations to his patient:

The ‘holistic health’ centre is situated near a town centre. The centre is shared by several CAM practitioners, including homeopaths, acupuncturists and chiropractors, as well as a psychotherapist. The patient, ‘Joe’, is a tall, slim woman in her late forties. This is a follow-up on her first consultation that took place one month earlier. Joe suffers from rheumatoid arthritis, which has progressed in the past few months. A conventional doctor offered to change her current medication and use a more aggressive drug therapy; however, Joe is determined to avoid this treatment. She hopes that homeopathy will help as a gentle alternative. Joe also suffers from bad migraines. Martyn sits next to Joe on the same side of the desk. He clearly puts effort into creating a relaxed, supportive environment that will make Joe feel comfortable. He is friendly, attentive, and speaks with a soft, relaxed voice. He is not trying to dictate or control the conversation, but rather to encourage Joe to speak her mind as openly as possible. Martyn asks Joe to describe her condition following her month-long homeopathy treatment. Joe answers quietly. ‘There is an improvement’ she says. The most striking improvement is in her migraine attacks. For several years she suffered migraine attacks almost every weekend, lasting all weekend long. Now, since she started taking the homeopathic treatment, they are almost gone. If she feels that a migraine is coming on, she uses the homeopathic remedy and it works. There is also some improvement with the arthritic pain, although not as striking. On at least three occasions Martyn refers to clinical trials, and how ‘clinical research tells us that this treatment is useful for…’ He talks quite a lot about a particular trial that he is involved with. During the first consultation Martyn prescribed Joe with one constitutional homeopathic remedy, supported by one symptomatic remedy. He also provided Joe with several nutritional guidelines, as well as with several food supplements to take on a daily basis. This is quite an eclectic approach, combining classical and combinations homeopathy, as well as non-homeopathic remedies. Martyn was quite keen to discuss Joe’s diet although she clearly struggles with this aspect of the treatment. ‘I am not very good with that’; ‘It is difficult’; ‘Soya milk is awful!’; ‘Never liked vegetables’, she says. Once again, he turns to scientific research to ‘sell’ his recommendation for Essential Fatty Acids (EFA) capsules. ‘Do you take this supplement?’ he asks. ‘Well I ordered it....’, Joe answers. ‘You know, research seems to be positive about this

supplement, although it does not seem to work for everyone', he says. Martyn opens a drawer and hands Joe a homeopathic remedy. 'This is for you', he says. 'I got it from a clinical trial that I am involved with. It is a 'complex homeopathy' remedy for arthritis. Use it next to the constitutional remedy if symptoms get worse'. Martyn's approach conveys an intriguing paradox. On the one hand he often makes spiritual and esoteric claims about homeopathy practice, several of which I quoted earlier in this chapter. At the same time he has a lot of respect for scientific research and he relies on it to boost his own practice. I will return to discuss this paradox in the next section as part of the concluding discussion of this chapter.

5.13 Concluding comments: pragmatic holism

The holistic discourse of NMQ acupuncturists and homeopaths that was discussed in this chapter reflects some of the tensions and dilemmas that are part of their professionalisation efforts, as well some of the strategies adopted by practitioners in an effort to negotiate these challenges. Fundamentally, the data shows that the holistic discourse is not static, but rather is influenced by dynamic, complex political and societal circumstances and by the way practitioners respond to such circumstances on both group and individual levels. There are a number of 'internal' and 'external' factors which influence the 'degree of holism' and the kind of holistic narrative that is expressed by practitioners. By 'internal' I refer to the nature and style of practice modalities in acupuncture and homeopathy and to practitioners' own practice approach, while by 'external' I refer to political and societal developments around the therapies organisation and practice. Having said that, I have demonstrated through the holistic discourse of acupuncturists and homeopaths, that the internal factors, to a degree, are also influences by the external ones.

Practitioners find themselves negotiating their 'loyalty' to the 'true' essential form of their esoteric knowledge and the holistic principles that are part of it, and the drive to formalise education, as well as satisfying demands for 'safe and

competent practice'. 'Externally' there is a pressure from the medical profession and from the government to emphasise biomedical knowledge and increase the input of evidence based medicine. At the same time, there is a certain consumerist demand by the public in relation to the level of holistic expression of practice on the one hand, and the level of integration of biomedicine and 'research evidence' on the other. 'Internally', the degree of holistic engagement is influenced by the style of acupuncture/homeopathy practice adopted by the individual practitioner, the personality of the practitioner, and the degree of reflectivity in relation to the holistic elements of practice. The careful negotiation and presentation of holistic concepts can be seen as strategies to move towards the mainstream while trying to maintain the unique and holistic nature of expert knowledge. At times, holism is used to demarcate acupuncture and homeopathy from biomedical science and demonstrate the unique nature of practice in relation to medical and allied to medical practitioners. On the other hand, however, holism is often downplayed, and a more medical model is adopted, and strategic actions are enacted by acupuncture and homeopathy practitioners to move closer to the mainstream. The conflict continues also in relation to the demarcation of knowledge claims from internal competitors. Demonstrating competency in relation to 'lesser' trained practitioners can be negotiated (as shown by Welsh et al. 2004) by emphasising the in-depth knowledge of the esoteric, 'traditional' knowledge, but at the same time it can be approached by increasing the gap via demonstrating increased knowledge of medical sciences. As we have seen in the data presented in this chapter, these tensions often lead practitioners to adopt what can be described as 'pragmatic holism', and a sort of adaptable holistic discourse in relation to circumstances and audience.

Pragmatic holism: adaptation of the holistic narrative in relation to settings, audience, and professional aspirations

In this chapter I examined the meanings that acupuncturists and homeopaths attach to holism as part of their holistic discourse and the representation of their practice, and practitioners' reflectivity in relation to a number of potential tensions in the holistic discourse. In examining the data it appears that around four

decades after the re-emergence of CAM as part of a medical counterculture, holism is still well embedded in acupuncture and homeopathy's rhetoric. At the same time it seems that the fact that there are many meanings attached to holism and the often 'generic', unspecific attachment of it to CAM, brings about a certain frustration amongst practitioners, fearing that it diffuses their professional identity rather than sharpening it. Such frustration might be linked with the tension between the dynamic nature of the holistic discourse, as opposed to seeing holism in its more 'essentialist' form as conveying the 'essential nature' of acupuncture and homeopathy. This frustration demonstrates the difficulty of practitioners to negotiate professionalisation which requires a degree of pragmatism in relation to their 'loyalty' to the 'purity' of their practice philosophy and of expert knowledge. Hence, it requires strategies that can be described as 'pragmatic holism', by which practitioners are hoping to move forward with their professionalisation efforts including the formalising of education, while maintaining the 'holistic appeal' of their practice.

The holistic concepts discussed by the study participants were mostly confined to categories of wider self holism. The first is that body, mind, and spirit are interrelated, although this notion is conceptualised somewhat differently by different practitioners and there is a degree of ambiguity in the way it is conceptualised. The second holistic notion commonly described in the data is that of the individualised nature of practice, and the matching of treatment to the unique constitution of the patient. Attached to this is a third, commonly mentioned holistic notion - the focus in practice on treating the root cause of the problem being addressed rather than merely treating its symptoms. It seems that the degree to which these three holistic concepts are followed in practice is heavily linked to several factors: the style of acupuncture/homeopathy practice used by the individual practitioner; practitioners' individual preference to engage with this kind of holism; and the need to compete in a biomedically driven market and communicate practice to potential consumers in a way that would appeal to them, driving a more symptomatic representation of practice. The fourth commonly mentioned holistic notion is that of enhancing the patients' natural healing capacities. Here too, the way of achieving the goal of stimulating the natural

healing forces varies between the different styles that were promoted by certain 'charismatic teachers' and adopted by different schools. Some acupuncture or homeopathy practice approaches take a more 'constitutional' approach while other approaches are less engaged with the patient's personal biography, and can be considered as less holistic in that respect. In relation to wider world holistic concepts, it is evident from the data that the practitioners who took part in this research had very limited awareness of the broad sociocultural and geopolitical environments of their patients and the impact of the broad environment over peoples' health. Although recently both the BAcC and SoH have made reference to this concern in their educational and practice policies, I found no signs of the development of such awareness amongst my participants, who did not seem to perceive it as part of the scope of their practice. This lack of orientation towards public health concerns might well be linked to the fact that most CAM is practised in the private market and in a certain professional isolation from the public healthcare sector. As discussed earlier in this chapter, the characteristics of CAM provision and consumption as commonly middle-class practice may well be linked with this lack of wider world awareness. As argued by Scott (1998, p. 200), it is not in private practitioners' economic advantage to locate the treatments in factors outside the patient's immediate control. I would argue that, while this lack of awareness of the broad environment is perhaps unintended and is circumstantial, it is not helpful in developing practitioners' orientation of contemporary healthcare concerns, and as such, it does not contribute to practitioners' efforts to move closer to the mainstream.

There are however, two areas of wider world holism that the study's participants are engaged in. Most striking is practitioners' attentiveness to the development of a democratic medical encounter that shifts the focus from the practitioner to the patient, whereby the practitioner is caring and is attentive to the patient's biography and 'storytelling', and the patient is encouraged to take an active role in the healing process. The second area of wider world holism that some of the study participants are engaged in is improving access to practice for people from low income groups by working in small charities at reduced fees. At the same time, this research echoes some of the critique of the holistic health movement

that was reviewed in Chapter Two. Increased interpretive authority is apparent mainly in the more 'constitutional' styles of practice, perhaps as a result of the increased degree of reliance on a) the patient's personal biography, including intimate, emotional and psychological details, and b) the intuitive and indeterminate nature of practice. There are clear efforts by practitioners in this study to develop a 'demedicalising' holistic discourse as part of protecting the unique nature of practice. At the same time, however, there are unintended tensions within the holistic discourse that may lead to increased medicalisation (Baer at al., 1998; Baer, 2003; Coward, 1989; Crawford, 2006; Goldstein, 2003; Lowenberg & Davis, 1994; Montgomery, 1993; Salkeld, 2005) including increased interpretive authority of the practitioner – and with it increasing the pathogenic sphere so that it includes more, rather than fewer aspects of day to day life as medical problems, and an unintended victim blaming as part of it.

There are a number of tensions in the 'demedicalising' holistic discourse that can be seen as part of more conscious strategies adopted by practitioners in light of external circumstances. The symptomatic representation through listing symptoms to be treated, adopting at times a less constitutional approach to practice, offering phone consultation in homeopathy, emphasising RCTs that evaluate the efficacy and safety of CAM in relation to specific conditions (rather than the whole person and the interrelations between body, mind and spirit), can all be seen as strategies enacted to respond to certain consumerist expectations, and move into, and respond to, a mainstream practice environment.

The complex nature of the practice environment and the tensions that are part of it in relation to the holistic discourse, highlight the importance of practitioners' reflectivity in relation to the nature of the medical encounter. Moreover, as Gale (2009) argues, in a partnership clinical model there is a potential for physical, psychological and emotional invasiveness, which requires reflective awareness by the practitioner regarding the power-relations in the medical encounter. Practitioners' reflectivity over matters of wider-self holism seems mixed, especially in relation to increased interpretive authority and the power-relations in the

medical encounter. Clearly, practitioners in my research are looking to narrow the social distance with their patients and develop a more democratic relationship that is attentive to the patient's perspective. A degree of reflectivity is naturally embedded in a medical encounter which requires the practitioner to be receptive and attentive, although it seems that some practitioners do not consider the potential sensitivities that are part of such participatory medical encounters.

Pragmatic holism 2: The paradox of infusing conventional biomedical research evidence into holistic practice

The notion of 'pragmatic holism' can be considered from the perspective that, as we saw in this chapter, practitioners often demarcate themselves from internal competitors while trying to maintain the holistic appeal of their practice and without alienating their clients-base. Quite often they chose to drop the degree of their holistic engagement and adopt biomedical explanations through the infusion of medical science into their narratives and into the way that they represent their practice. This is evident by the utilisation of biomedical concepts into the description of practice and the inclusion of biomedical/scientific research evidence and RCTs on practitioners' websites or as part of the justification of the therapeutic strategy. It seems that practitioners were trying to 'juggle' between the adherence to professionalisation of their practice and increasing their credibility-status as knowledgeable, safe practitioners on the one hand, and the desire to maintain the secrecy of their esoteric knowledge and its appeal to their clients on the other. Such 'infusion' of medical science into the organisation of knowledge was also apparent in other studies on acupuncture and homeopathy (Welsh et al., 2004), demonstrating the 'tension between their claims for scientific knowledge and their "alternative" medical focus' (ibid, p. 236). As Welsh et al. point out, the infusion of medical science into CAM can be seen as the attempt to gain professional dominance and a degree of social closure over rival groups and rival schools, and align acupuncture and homeopathy practice with mainstream medicine. At the same time, including biomedical knowledge should also be seen

as important in ensuring that practitioners are safe and familiar with biomedical interpretations and terminology.

My findings support the previously described trend of the narrowing of the 'holistic-reductionist gap' between CAM and biomedicine that was evident in other research (Cant & Sharma, 1996a; Hollenberg, 2006; Walsh et al., 2004), in which practitioners aligned themselves with the biomedical paradigm and downplayed some of their esoteric knowledge claims . Nevertheless, I use the word 'downplay' to point at the way that practitioners did not drop their holistic ideology, but rather moved it from the centre of their practice-representation to a less noticeable position, and in so doing are perhaps trying to adopt a more mainstream appeal. Not only do acupuncturists and homeopaths often rely on the high status of biomedicine in society and use biomedical claims to increase the credibility of their practice, paradoxically, they also use it to support some of their holistic claims. This is despite the commonly mentioned critique of the unsuitability of RCTs to examine acupuncture and homeopathy (Keshet, 2009; Barry, 2006). Biomedical research can be seen as highly political in that it used by biomedicine to maintain its dominance, reinforcing biomedicine's existing structures on acupuncture and homeopathy. Jackson and Scambler (2007) argue that to establish itself in the West, acupuncturists appealed to biomedicine to gain legitimacy, and practitioners, despite challenging biomedical research, conformed to using it to gain external legitimacy. I am not quite sure that practitioners in my study were reluctant to using RCTs. Rather it seems they adopted a strategic approach to using it, and some practitioners were happy to highlight positive findings on acupuncture with pride, not only as a 'reluctant strategy'. It is not uncommon to come across practitioners who amend or 'force' biomedical claims in a way as to make them appear to support unscientific claims. Moreover, while acupuncturists in a study by Jackson & Scambler (2007) showed scepticism and ambivalence towards biomedical evaluation of their practices, many practitioners in my study use RCTs on their website to increase their external legitimacy.

In Chapter Three, I discussed the way professions distinguish themselves from other occupations by the unique nature of the expert knowledge that is required to perform the professional task (Timmermans & Mauck, 2005). Supporters of EBM see it as way of creating practice guidelines and as a solution to variations in practice and to clinical uncertainty. As Timmerman and Mauck point out, such variation and uncertainty puts in question the professional nature of expert knowledge as it seems to vary randomly (ibid, p.21). Developing standard clinical guidelines that are based on rigorous scientific evaluation provides medical practice with credibility. In contrast, as discussed in Chapter Three in relation to indeterminacy and technicality ratio (I/T ratio), such routinisation of expert knowledge can lead to its transparency, providing access to 'third parties' from outside the profession (Jamous & Peloille, 1970). Such process, opponents of EBM argue, can limit practitioners' autonomy, tie them to external legal demands, and reduce the credibility of the profession. This process of standardising expert knowledge, it is feared, is taking away the 'secrecy' of the profession.

Certainly, these concerns over the current EBP drive and the critique over the way EBP is influencing health care delivery are not restricted to CAM. The tension deriving from a 'controlled', standardised clinical practice that takes away from the indeterminate, experience-based, intuitive nature of expert knowledge and the artistic skills of the practitioner, is also discussed in relation health and care professions such as nursing (Gilgun, 2005), mental health nursing (Welsh & Lyons, 2001), social work (Webb, 2001), medicine, and other health care professions (Timmermans & Mauck, 2005). For example, the requirements to include the teaching of EBP in HPC professions' education are established in the HPC's *Standards of Education and Training* (Health Professions Council, 2005, p. 5). For example, some similarities in the way the drive to professionalise includes pressure to increase biomedical research into practice that is not grounded in biomedical enquiry, can be observed in the case of social work. Very recently, social work moved to a position of a recognised profession by joining the HCPC. In terms of formalising education, it is only since 1971 that social work training has been regulated and studied at diploma level (Horner, 2003). It is only since the Care Standards Act in 2000 that social workers are trained at BSc (Honours)

degree level. In relation to social work too, the notion that practice should be delivered by research informed evidence, underpinned by rigorous, standardised research methodologies, was becoming increasingly prominent in education and practice (Webb, 2001). The document *Standards of Proficiency for Social Workers in England* (Health and Care Professions Council, 2012) indicates that social workers should be able to engage in 'evidence informed practice' and have an understanding of research and research methodologies. According to Webb (2001), amongst the contributing factors to the emergence of EBP in social work are the dominance of medical and health care research, and government policies 'aimed at developing a "performance culture" by controlling quality, optimizing effectiveness and reducing risk' (ibid, p. 60). Much like in the case of NMQ acupuncture and homeopathy, discussions between advocates of EBP (for example Sheldon, 2001) and those who are critical of this approach (for example Webb, 2001) are debated by social workers educators and practitioners. Here too some argue that EBP ignores the complexity of the actual decision-making processes. Much like in arguments made in relation to EBP and CAM practice (Barry, 2006; Keshet, 2009) it is argued that standardising social work encounters ignores the uniqueness of the particular situation ('situatedness') and the unique identity of the people who are part of the social work encounter (Webb, 2001).

Such discussion in relation to EBM resonate similar discussions in the CAM context. While there is a substantial growth in the number of RCTs on CAM therapies, as well as increasing number peer reviewed scientific CAM journals (Welsh et al. 2004), this drive can be interpreted as deeply political (Barry, 2006) as it is dominated by biomedicine to ensure its control and powerful position. However, the use made by NMQ acupuncturists and homeopaths in biomedical research and RCTs, and the infusion of biomedical terminology into their holistic narratives, can be seen as a way of demonstrating to the medical establishment, to the government and to the public, that practitioners are safe and qualified. Therefore, we witness practitioners such as Martyn, who uses unscientific, esoteric descriptions of practice with strong emphasis on the holistic elements of homeopathy, and at the same time advocates for biomedical research in CAM while using findings from RCTs to support his holistic.

Acupuncturists' and homeopaths' holistic discourse is clearly inseparable from their professional identity. However, the nature of this discourse reflects the dynamic nature of their practice environment and the way that practitioners respond to this environment. Therefore, the fluidity of holism, and the frustration it brings to some practitioners as a result of this fluidity, is not surprising. Holism is not a static point of reference which practitioners and scholars are continuously failing to capture. Rather, the holistic discourse is a reflection of a relationship between the unique nature of expert knowledge, and the social, cultural and political environment in which this knowledge is negotiated by the practitioners themselves.

Since the mid-1990s both therapies' professionalisation efforts have included the teaching of courses in co-operation with British universities (Isbell, 2004). Since knowledge transmission and the presentation of expert knowledge is an important part of professionalisation (Cant & Sharma, 1996a), it is important to examine this process in the context of professionalisation strategies, and how the holistic discourse of the therapies is negotiated during the formalisation of education. In the next empirical chapter I will examine how acupuncture and homeopathy's holistic concepts are contested in a process that is dominated by biomedicine (Clarke et al., 2004; Hirschkorn, 2006, p. 548).

Chapter 6

Negotiating content and context of knowledge in acupuncture: formalising education while guarding holistic claims

In the previous chapter I discussed the holistic discourse of NMQ acupuncturists and homeopaths in England as a dynamic discourse which reflects changes and challenges in and around their field of practice. I discussed the role of this discourse in practitioners' representation of practice, the strategies employed by practitioners to negotiate challenges to the holistic nature of their practice, as well as practitioners' reflectivity in relation to their holistic practices. In the next two chapters, Chapters Six and Seven, I move from the focus on the holistic discourse of individual practitioners, and the strategies that individual practitioners employ to negotiate tensions between this discourse and formalising education, to examine the way that the professional communities of NMQ acupuncturists and homeopaths, i.e. practitioners, their schools, the trainees, and the professional bodies, negotiate these tensions. The process of formalising and standardising *knowledge content* is a major part of practitioners' efforts to achieve legitimacy for their knowledge claims and increase their professional status. Hence, the way *knowledge content* is negotiated is an important element in the shaping of *knowledge context*. In this chapter, I will examine the case of NMQ acupuncturists, while in Chapter Seven I will discuss the case of NMQ homeopaths.

6.1 Research questions and data sources for Chapters Six and Seven

The following research questions are examined in Chapter Six (acupuncture) and Chapter Seven (homeopathy):

- How do NMQ acupuncturists and homeopaths negotiate the holistic premise of their practice in the course of formalising their educational structures?

- What is the impact of HEIs (Higher Education Institutions) on acupuncturists and homeopaths' holistic ethos and holistic engagement?

Chapter Six and Chapter Seven draw on data from:

a) Participant observation of teaching that took place during the final year (level 6) on BSc (Hons) Acupuncture at a school for Chinese medicine in England during the academic year 2007/8.

b) Acupuncture/homeopathy course information taken from 14 BAcC and 13 SoH accredited schools.

c) Educational/practice guidelines published by the BAcC and the SoH.

d) In-depth interviews with nine acupuncture/homeopathy educationalists, including four school principals and five lecturers, as well as data from interviews with practitioners.

The chart below links the discussion of acupuncture and homeopathy's holistic discourse (Chapter Two) with the challenges that this discourse brings with it to the therapies' professional projects and the formalisation of education (as discussed in Chapter Three). Amongst these challenges are: a) the difficulty of schools and leaders to achieve unification and agree on professional boundaries and definitions, and standardise education while maintaining the unique ethos and approach to practice of each school; b) the difficulty of standardising an indeterminate kind of knowledge; c) the paralleled increased input of biomedical knowledge and research in training which is feared to obscure the holistic, artistic and intuitive aspects of knowledge and of practice in acupuncture and homeopathy; d) as a result, the concern that standardisation lowers the I/T ratio which may reduce the 'secrecy' of the profession and will lead to increasing the transparency of expert knowledge to 'externals'; and e) the external involvement of HEI's and with it practitioners' fear of losing control over the form and the nature of expert knowledge transmission in favour of 'cold', formal, bureaucratic process. The data reviewed in this chapter was considered in the context of these challenges, which are presented in figure 9 (below). The holistic discourse in

acupuncture and homeopathy is placed at the centre of the chart. It is 'surrounded' by the challenges it brings with it to the formalisation of education in acupuncture and homeopathy:

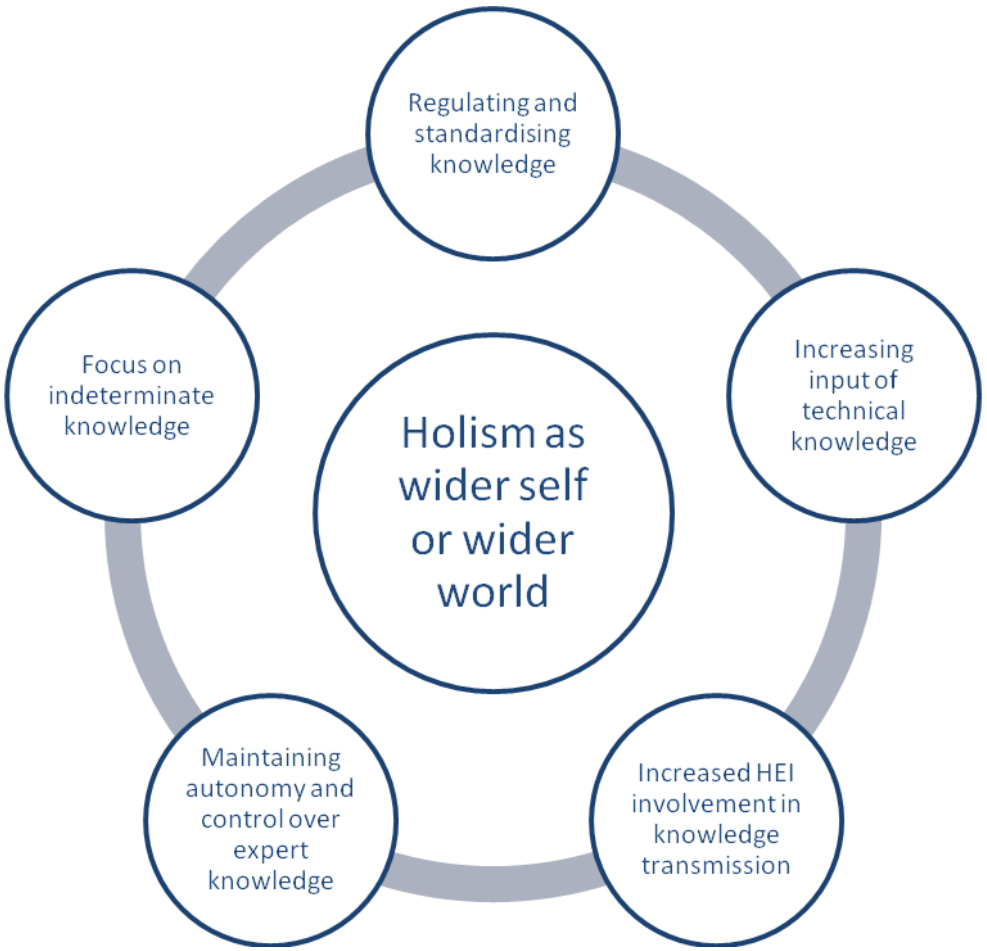


Figure 9: Tensions between the holistic discourse and the formalisation of educational structures

In presenting the data, I will first discuss the findings from my participant observation which took place, for the purpose of maintaining anonymity, in an unnamed school for Chinese medicine, during the academic year 2007/8. This participant observation provides insights into the way that the teaching staff and students (and therefore future practitioners) experience the process of formal education, validated by a university, and the way that the aforementioned challenges are negotiated by staff and students. Following the discussion of my participant observation I will move on to discuss data from interviews with practitioners, educators and school principals; acupuncture courses' information; and BAcC educational/practice documents.

6.2 Participant observation: BSc (Hons) Acupuncture in a private school

In 1980, several disparate societies of NMQ acupuncturists in the UK were unified with the establishment of the Council of Acupuncture (Saks, 1999). This process enabled the development of common standards of education, ethics and practice for acupuncture. A decade later, the British Acupuncture Accreditation Board (BAAB) was established, setting standards of professional education in acupuncture within the UK through a formal process of approval. The process of formalising acupuncture education was further developed in 1995 with the establishment of the British Acupuncture Council (BAcC), which ensures that accredited acupuncture courses meet defined educational criteria and standards (Jackson & Scambler, 2007). With time, the BAcC and the BAAB developed detailed educational and practice guidelines. Despite the diversity of schools, teaching a number of different practice styles, a core curriculum was developed, with significant degree of standardisation. According to the BAAB, the accreditation procedure of acupuncture courses involves a rigorous three to six year process through which teaching institutions progress from a 'new programme proposal' (NPP), through provisional accreditation (PA) and finally to full accreditation. During 2010, out of the 14 BAcC accredited acupuncture courses, eight were taught within universities and six by private schools. With the exception of one school, all BAcC courses were taught at undergraduate level, obtaining university validation. During 2011, two university courses and two private schools stopped recruiting. One of the largest acupuncture schools encountered financial difficulties and was closed after 18 years of delivery of acupuncture education. According the BAcC website, all members of the Council study traditional acupuncture in courses lasting over 3,600 hours. The curriculum includes the teaching of traditional acupuncture, the philosophy and theory of Chinese medicine, as well as biomedical sciences including anatomy, physiology and pathology, at a BSc/BA level or equivalent.

Therefore, as discussed in Chapter Five (section 5.13), this process of formalising acupuncture education involves a degree of alignment with biomedicine and an increased emphasis on human biology and RCTs (Jackson & Scambler, 2007; Saks, 1999). Acupuncture schools, guided by the BAcC, are looking to increase their external legitimacy and demarcate themselves from the public and from 'untrained practitioners', by moving towards the mainstream and signal safe and competent practice by increasing biomedical knowledge. As argued by Cant (2009), CAM delivery is shaped by the rhetoric of a safe and responsible practitioner that embodies professionalism, the preference to a therapeutic relationship in which the practitioner's expert position is emphasised, and the precedence to biomedical scientific evidence in validating practice. The question is how such alignment with biomedicine, linked with safe and competent acupuncture practice (Welsh et al., 2004) can be done without losing the holistic ethos and the 'holistic attraction' of acupuncture. This is indeed a complex operation with conflicting motivations and aspirations for NMQ acupuncturist, educators and trainees. Moreover, it is not clear how acupuncture schools, diverse as they are in their approach to acupuncture theory and practice, unite in an effort to standardise acupuncture education while maintaining their unique ethos. A particularly challenging question is the students' perspective, and how acupuncture students negotiate the tensions between the increase in technical, biomedical knowledge, with the high degree of indeterminacy that is part of many CAM (Clarke et al., 2004; Hirschkorn, 2006), and whether it affects their holistic narration of acupuncture.

During the academic year 2007/08 I was presented with an opportunity to conduct a participant observation on one of the BAcC accredited, university validated acupuncture courses. I was invited to join the academic team of the school and take part in the supervision and assessment of students' enquiry projects, part of their final year (level 6) of the BSc (Hons) in Acupuncture. I was assigned the supervision of six students. I met these students for tutorials on several Saturdays at the school; I also communicated with them via email in relation to their progress. Towards the end of the academic year, I took part in the assessment and marking of 22 dissertations and 12 oral presentations of the students' enquiry project. A year later, I returned to the school and observed another set of

students' presentations. This participant observation provided me with valuable insights into the challenge of introducing academic benchmarks into CAM education, the difficulty of teaching biomedical research methods on a traditional acupuncture course that is founded upon non biomedical principles, and negotiate the holistic elements of acupuncture in that process.

Before moving on to describe and discuss my participant observation at the acupuncture school, I would like to take a moment to discuss the term 'participant observation' in the context of my study. Although participant observation is an inherent part of ethnography, and indeed the terms are often used interchangeably, I would like to stress that the following section should be seen as *informed by ethnography*, rather than an ethnographic study *per se.* In other words, I used participant observation as a research *technique* within the particular setting of the acupuncture school. As Atkinson and Hammersley (1995) point out, for some scholars ethnography is a philosophical paradigm which requires total commitment, while others see it as an instrument that can be used where and when appropriate. Indeed, Gobo (2011) suggest that while the terms 'participant observation' and 'fieldwork' are merged with ethnography, they should not be mixed up. 'Fieldwork' underlines the prolonged presence of the researcher in the field, and 'participant observation' is a distinctive research strategy:

> 'Participant observation' is a distinctive research strategy. Probably participant observation and fieldwork treat observation as a mere technique, while the term ethnography stresses the theoretical basis of such work stemming from a particular history and tradition (Gobo, 2011, p.16).

For the majority of my observation I attended the acupuncture school as a member of staff, which allowed me to collect data first hand while interacting with staff and students, exploring their perspective in relation to the complexities that are part of formalising education. Therefore, I was able to observe 'human meanings and interactions as viewed from the perspective of people who are insiders or members of particular situations and settings', located in a 'here and now of everyday life situations' (Jorgensen, 1989, p.13). My participant observation involved becoming a member of the observed organisation as a

temporary member of staff, and establishing direct relationships with the social actors (students and staff at the acupuncture school) in their natural environment, while interacting and participating with their 'everyday rituals'. This included attending staff meetings, teaching, preparing academic material, chatting with students in the kitchen while discussing the food that we had for lunch, meeting with students to discuss their academic work and observing students' presentations. It involves, to a degree, soaking the atmosphere at the school and exploring the culture that is expressed by students and staff as well as the interaction between them.

Yet, the degree of my participation cannot be described as 'pure' ethnography in that it was limited by the fact that I attended the acupuncture school in monthly intervals, for several hours each time, over several months, rather than prolonged and intensive engagement with 'the field'. Therefore, this level of intensity in my observation did not allow me to fully immerse myself in the field of inquiry in the same way that ethnographic studies usually do. While I tried to provide a detailed description of my observations within the school, the fact that there were significant intervals between my attendances (coming coming 'in' and 'out' of the observed setting), I found myself being particularly careful in the way that I narrated, transcribed and 'translated' my participants' interactions and behaviour.

Nevertheless, the observations that I conducted as I temporary member of staff allowed me to move beyond merely describing the teaching setting in bare details, to a more elaborate description of the atmosphere, dynamics and interactions taking place in the classroom and the wider school setting – or as Geertz (1973) described it, moving from a 'thin' description towards a 'thick description'. Hence, whilst recognising that this effort was limited by the aforementioned factors, I do believe that my observation 'sessions' are a valuable contribution to my research data as a whole. Hence, I refer to my participant observation in the context of what Gobo describes as a technique which complemented other data sources. I have used my participant observation alongside in-depth interviews and documentary review, which were gathered at the acupuncture school, as well as to complement other data sources in the overall study. Therefore, it is important to

see this segment of the study not in isolation from other data sources, but rather as integrated in the broader 'patchwork'.

The setting

The acupuncture school was founded in 1992 by two 'charismatic teachers' (see discussion of the term in Chapter Three). In their first year they had just eight students and the school had no premises of its own. Three years later the management of the college was put in the hands of the current principal. Since then the college has grown to reach an approximate total of 400 students during the academic year 2007/8. The college is placed in a modern building in a high street location. The acupuncture course is the main, but not the only, course at the school. Other courses are oriental herbal medicine, *tui na*, *qi gong*, and nutrition. The acupuncture course was accredited by the British Acupuncture Accreditation Board (BAAB) in 1998, and validated as an undergraduate BSc (Hons) Acupuncture by a British university a few years later. As soon as I joined the academic team I received an employees' handbook and a lecturers' handbook- a comprehensive guide concerning formal and academic procedures, such as employment conditions and policies, disciplinary processes, and invigilation instructions. The school itself is impressively equipped with modern teaching facilities, a large administrative area, a small library, an in-house herbal dispensary, and a space for students to socialise, have their lunch or sit and read. There is certainly a sense of a small community and both students and staff are very friendly, to the point that it feels almost rude to not greet whomever one comes across while walking down the corridor or entering the kitchen. It seemed as if everybody knew everybody there.

One of the issues I wanted to observe in relation to the process of formalising acupuncture education is whether the degree of 'formality' in the delivery of courses is influenced by the process of university validation. The process of formalising education involves the development of common standards of education in acupuncture (Saks, 1999) and the assurance that accredited acupuncture courses meet defined educational standards (Jackson & Scambler,

2007). However, as the three acupuncture school principals were keen to emphasise (see section 6.8 in this chapter), formality is not just about the taught knowledge, it is also about the teaching approach and the teaching space. It is a about the school as a space of 'holistic teaching', the atmosphere at the school, the personal approach, the sense of community, students' sense of belonging to the school - in a way it is about being 'informal'. There is a certain fear that the bureaucratic and formal nature of HE will take over from the 'warm', informal teaching approach at the schools. Similar concern was expressed in relation to homeopathy (Sharma, 1996) during the shift to formal educational structures. Sharma described 'informality' as still being a characteristic of homeopathy education, where 'smallness' and intimacy are perceived by educators as positive virtues and as student-inspiring. The acupuncture schools, too, commonly highlight on their websites the intimate, personable nature of their courses, which, unlike university courses, maintain a sense of a 'small community'.

The informal nature of the school where I conducted this observation was felt from the moment I walked in. I was greeted by a blend of smells of aromatic oils and herbs. The kitchen and the communal area is where students took their tea break and lunch, serving as a central meeting place for both staff and students. What was striking was the lack of formality and the personable relationships between lecturers and students. There was no sense of 'distance' and it was not uncommon for lecturers and students to sit side by side on the sofa, eat and chat to one another. There was certainly a more relaxed atmosphere than what one usually finds within a university. The small space that was shared by students during breaks brought about a sense of community where people from the different courses got to know one another. The more I was in the common area, the more I felt as if I was going back in time to when I was a naturopathy and homeopathy student in a college in Tel Aviv, as well as a lecturer in two other CAM colleges. There is a certain accumulation of impressions that aggregate into a certain kind of 'emotional scenery', which I attach to this particular kind of 'holistic school setting'. The blend of smells of herbs from the dispensary, moxa from the treatment rooms and aromatic oils from the shop; the relaxed atmosphere; the physical space itself – small and clean rooms, artefacts and paintings on the walls; the nature of conversations (for example many discussions

were about healthy food and healthy cooking), all reminded me of previous experiences in other CAM schools. In my own mind, it brought about a certain tension between the warmth and 'personability' of the school on the one hand, and a sense of insecurity due to the 'informality' of the school on the other, and the uncertain status of CAM as part of it. And there I was, attending a school which teaches a BSc (Hons) Acupuncture that is validated by a British university, and yet I could still not shake of this feeling of uncertainty.

The academic team at the school come from a range of professional backgrounds. Some were employed on the basis of their professional merit and reputation as acupuncturists, while others on account of their academic merit. Nevertheless, most lecturers had both professional and academic credentials. At least three of the lecturers were medically trained, and several other practitioners have allied-to-medicine qualifications, such as nursing, medical imaging and biological research. While the school has put in place all the formal structures that are required to fulfil the terms and conditions set out by the validating university, it still maintains a very informal atmosphere in and out of the classroom. During my interview with Lucy, the school principal, she was keen to emphasise the warm, personable, and friendly approach that the school wishes to maintain despite the process of formalising its courses and aligning teaching with the requirements of both the BAcC and the validating university. Indeed, the school has a unique blend of what I would describe as an 'informally academic' environment which seems to reflect a desire to maintain some informality alongside cultivating a standard academic processes and procedures. The school publishes a monthly in-house magazine which features both biomedical and traditional acupuncture/non-biomedical articles collectively. For example, the magazine's autumn 2010 edition featured an article entitled *the importance of Chinese medicine research for the novice acupuncturist* next to an article about *exercises to measure your own qi*.

The 'Enquiry Skills' unit

'Enquiry Skills', the unit on which I taught as a temporary member of staff, is a 30 credit unit, part of the three-year full-time BSc (Hons) Acupuncture. The unit, which takes place at level six (third year on the full-time course and fourth year on the part-time course), requires students to developed critical skills according to the level-based guidelines and learning-outcomes. Following the BAcC Education Board guidelines, this unit aims to equip acupuncture students with a basic knowledge of biomedical research in line with the evidence-based practice approach. The aim of the unit is described in the unit handbook:

> In Enquiry Skills unit (ES) we aim to promote your understanding of the value of informing your practice by credible and valid evidence. We hope to facilitate your professional growth by encouraging you to look into your practice and engage in objective evaluation of research material.

During this unit, students acquired introductory knowledge on conducting biomedical research and developed skills that would allow them to look for, and critically consider, published research. This in turn enabled them to develop their own investigation into a clinical aspect of acupuncture practice. Students were introduced to the concepts of scientific research, inductive (qualitative) and deductive (quantitative) research, including approaches to research design, data collection and data analysis. Students were assigned to a supervisor and developed a project proposal, followed by an investigation of a clinical concern in the form of a literature review. They presented their findings in a dissertation and through an oral presentation. In their dissertations students were instructed to review the literature from both Chinese medicine and 'Western medicine' perspectives in relation to the clinical concern being investigated. This required them, in effect, to synthesise technical (biomedical research) and non biomedical (Chinese medicine theory) knowledge. The assessment criteria of the unit Enquiry Skills looked rather similar to other research methods units on other Health Professions Council (HPC) professional courses. I noticed many similarities in themes and content between the unit Enquiry Skills and the unit 'Introduction to

Evidence-Based practice' that I am coordinating at the University of Portsmouth as part of the courses Paramedic Science and Operating Department Practice, both HPC regulated professions. Both units share several similar learning outcomes, including:

- Outlining the importance of evidence as a basis for clinical practice
- Applying appropriate means for identifying and retrieving evidence online
- Describing the range of methods used to research practice
- Considering the ethical implications of the use of research in health settings
- Reviewing an article on a chosen area of clinical practice using a review tool

The unit was also quite similar in content to the unit 'introduction to research methods' that I coordinate as part of the course BSc (Hons) Human Physiology. Students on the Enquiry Skills unit are required to formulate an enquiry question in a manner that follows an evidence-based practice approach; develop a project plan; identify suitable published research; appraise it; and reference their work, all according to academic standards that are guided by the validating university. While working on their dissertations, students are introduced to basic quantitative research terminology, including some statistical terms such as 'reliability', 'validity', 'bias', 'error', 'power' and 'standard deviation'. Once students completed and submitted their dissertations, they presented their work in front of their peers. The presentations were assessed and marked by two academic staff from the college according to a marking scheme that included the following criteria:

1. Introduction: Enquiry problem/ statement in the field of acupuncture: Formulation & focus of enquiry question; Focus of introduction around subject; Rationale to enquiry question
2. WM (Western Medicine) and TCM (Traditional Chinese medicine) chapters: Range of sourcing. Focus around enquiry question/ Statement
3. WM and TCM chapters (Should be in the style of literature review): Evaluation of sources, analysis and synthesis to a cohesive theory
4. Detailed critiques: Choice of sources. Appreciation of methodological issues; Awareness of strengths and weaknesses as come across in the individual critiques and in the comparison between the studies

5. Discussion: Use of information to sustain conclusions; Implications for practice and future research
6. Project as a whole: Internal consistency; Relevance to enquiry question/ statement
7. Referencing; Presentation; Use of language

Below is a list of some of the titles of students' projects, all of which were in the form of a literature review:

- Acupuncture in the treatment of Postpartum Depression (PPD)
- Is traditional acupuncture as effective as Western interventions in the alleviation of the pain experienced in Fibromyalgia Syndrome?
- Acupuncture in treating pain in cancer patients
- Acupuncture in the treatment of frozen shoulder
- Acupuncture in the rehabilitation of stroke patients
- Acupuncture in the treatment of mild depression
- Adverse events in Acupuncture – what are they and do they render the practice unsafe?
- Acupuncture in the treatment of Interstitial Cystitis/Painful Bladder Syndrome

The focus of students' projects is on a clinical evaluation of effectiveness, efficacy and safety of acupuncture as a medical intervention. There is clear effort by the academic team to guide students to develop critical skills, including a critical consideration of acupuncture as a useful medical intervention. For example, as part of the marking criteria for the dissertation students are required to maintain an 'objective comparison of [Western medicine and traditional Chinese medicine] resources, and sophisticated synthesis of information into a cohesive theoretical framework'. In relation to the evaluation of the resources that are employed as part of their dissertation, students are required to demonstrate

> Extremely systematic and perceptive analysis of strengths and weaknesses. Originality and rigor in discussing implications for practice and future research.

However, perhaps as a result of the anti-reductionist and anti-oppressive holistic discourse that is often found in CAM, it proved difficult for students to obtain the same degree of rigour and critical view for acupuncture and biomedicine. In comparing traditional acupuncture and biomedical perspectives of clinical problems, students were often keen to demonstrate the shortcomings of biomedicine next to the advantages of acupuncture. The result, quite often, was a very critical examination of the biomedical perspective and an uncritical evaluation of acupuncture and its benefits. For example, in his dissertation, one of the students compared acupuncture and biomedical interventions in the treatment of fibromyalgia, while emphasising the shortcomings of biomedicine in treating the condition. He highlighted the lack of consensus by conventional doctors over the condition's diagnosis and the limitations of conventional drug therapy. In contrast, he described acupuncture as an effective, safe treatment, and as a holistic approach that addresses 'the root cause' of the condition.

Another student considered adverse events in acupuncture, comparing it to adverse events in conventional medicine. She, too, did not seem to apply the same degree of critical evaluation towards acupuncture and biomedicine. In her dissertation she described the limitations of conventional medicine in treating chronic conditions, while, in contrast, she presented acupuncture as an effective treatment for such conditions, without considering such broad statement more critically. I will now move on to describe students' presentations of their enquiry projects.

Students' presentation, April 2008

The first series of presentations, which I attended as one of the two assessors, took place on 30th April 2008, the students' last study day on the course. The other assessor on the day was Annabel, who was trained in China as a medical doctor (gynaecology) as well as an acupuncturist. The assessment criteria that we were asked to use had the following broad criteria:

1) Delivery: Audibility, pace and manner, eye contact and use of supporting materials, time consideration.

2) Structure: Statement of aim/s and structure of presentation, logical structure, summary

3) Content: Enquiry question/ statement and its justification

4) Content: Discussion of findings and conclusions

The atmosphere in the teaching room was strikingly informal, very different to that which I was used to at the university where I lecture. Students sat with their legs on the chairs in front of them looking rather laid back. The first student presented while sitting on a desk and swinging her legs from side to side, looking very casual. While presenting, students often exchanged jokes with their peers. As the presentations went on, it was quite clear that presenters' general perception of conventional medicine was rather negative. In fact, often students referred to acupuncture as 'us' and to conventional medicine as 'them', describing conventional medicine as 'short-sighted', 'reductionist', 'unsuccessful', and 'aggressive'. In contrast, very few critical comments were made in relation to acupuncture. At least four of the presenting students described acupuncture as 'holistic', without trying to explain or contextualise holism and it seems that it was used as a sort of a generic, unspecific attachment to acupuncture. Students often considered textbooks that were written by known acupuncturists as unchallenged evidence to support claims for the benefits of acupuncture. In contrast to several critical comments made of scientific research, acupuncture textbooks were always presented without criticism. This was despite it being the case that such textbooks

are often based on the author's personal interpretation of Chinese medicine theory. For example, the well known textbook *The Foundation of Chinese Medicine* by Giovanni Maciocia was often cited by presenters as a form of evidence to support the effectiveness of acupuncture in treating certain conditions. On its cover, the content of the book is described, as relying on the creative interpretation and vast practice experience of the author. The book itself does not contain evidence from clinical research:

> This comprehensive and scholarly work brings together the complete theory of Chinese Medicine in a detail never before available in the West. The author's understanding of the Chinese language has allowed him to refer to ancient Chinese classics, as well as to modern textbooks. Key features include ... creative adaptation of Chinese Medicine theory to Western clinical conditions. ... Through this unique volume, he [the author] allows others to share in his deep understanding of the subject and to benefit from his extensive clinical experience (Maciocia, 1989).

This view of seeing the knowledge of 'acupuncture authorities' as unchallenged evidence is intriguing considering the emphasis of the unit Enquiry Skills on critical evaluation of the literature. Students seemed to demonstrate critical evaluation in relation to biomedical research but not in relation to acupuncture textbooks. I discussed some of my observations with Sue, an acupuncture lecturer at the college, who was also involved with the delivery of the unit Enquiry Skills. It was clear that students' negative perception and negative presentation of Western medicine was an area of concern that the course team was aware of and was trying to address:

> This [negative representation of Western medicine] is something that as a college we are trying to discourage. Certainly I have. And in particular when I was teaching 'Integrated Practice' I was getting a fair bit of resistance to the idea of learning more Western medicine. I was teaching Western medical examination skills and combining them with Chinese medicine skills. Some students loved it and others you know …'why do we have to do this'.
>
> I think it has filtered down, and it is being expressed in academic meetings, that it is inappropriate for students to be saying this [acupuncture is 'good'

> and conventional medicine is 'bad']. We also used to see it quite a lot in the dissertations. … It is something that is certainly in team meetings in the ES group [Enquiry Skills unit] we've been discussing, and we are trying to find ways of discouraging that because we feel it is entirely inappropriate. It doesn't do anybody good service.

Not aware that this is not common practice at the school, from time to time Annabel and I asked presenters questions to clarify aspects of the presentations' content which we were not clear about. This appeared to make several students uncomfortable, although we did not present our questions in a confrontational or argumentative manner. To our dismay, following half a dozen presentations, one of the students stood up and accused us of 'grilling' the presenters with our questions, for 'crucifying them', and for instilling too much stress in the students who were yet to present. Several students supported this view and the atmosphere in the teaching room became quite uncomfortable. We called for a 20 minute-break to calm the atmosphere. Two students came to me during the break to express their disagreement with the comments made by their peers. For the rest of the day we found ourselves being very careful, hardly asking questions about students' work. I was not aware that as a result of a similar situation that happened during the previous year, it was decided by the lecturing team that academic staff should not pose any questions during presentations or discuss aspects of a presentation's content in front of the other students. To my surprise, an email from the unit coordinator followed, asking staff to avoid from asking questions during presentations. The discouragement of academic staff from presenting questions in relation to students' work surprised me. The detailed assessment criteria clearly guided students to demonstrate critical awareness:

> Thorough, sophisticated justification and consideration of global context. ... Sophisticated use of information gathered to support conclusions.
>
> Originality and rigor in discussing implications for practice and future research.

This was, after all, a unit which was designed to encourage students to develop academic curiosity and, with it, self-criticism, which stand at the centre of the critique of CAM as lacking self critique and for not actively seeking to apply a 'healthy sense of self-scepticism' (Peters, 1998; Vickers, 1998). In the following

year I received permission from the school principal and from the unit coordinator to attend students' presentations once again. I was hoping to re-visit some of the observations I had made the previous year. This time I was not involved with the supervision or the assessment of students' work, and I attended as a 'passive observer'.

Students' presentations, May 2009

A year later, on my return to observe students' presentations, the atmosphere was more formal than the previous year. The topics of students' research projects were once again clinical in nature, clearly pursuing an evidence-based practice approach. Topics on the day included the following:

- Acupuncture in the treatment of hyperemesis gravidarum[37]
- Acupuncture in the treatment of nausea and vomiting in early pregnancy
- Acupuncture as an adjunct to Western medicine in the treatment of bell's palsy[38]
- Acupuncture in the treatment of migraine
- Do haematological systems have any equivalent in Chinese medicine and what value they have to acupuncture research
- Pseudobulbar palsy[39]: acupuncture versus Western medicine

During the presentations students made reference to biomedical terms and concepts that could have been used during any 'hard science' courses such as human biology, pharmacology or biomedical science. For example one student described the coagulation cascade and the morphology of red blood cells while another student described electrolyte imbalances deriving from uncontrolled vomiting during pregnancy. However, despite the common reference to

[37] Hyperemesis gravidarum is uncontrollable vomiting during pregnancy which may cause fluid and electrolyte imbalances leading to nutritional deficiency.
[38] Bell's palsy is a weakness of the facial muscles. It develops suddenly, usually on one side of the face.
[39] Pseudobulbar palsy is a speech problem resulting from brain damage that may follow stroke, brain injury or neuro-motor diseases such as multiple sclerosis (MS).

biomedical concepts, like the previous year, students maintained a negative presentation of biomedicine. In contrast they did not demonstrate a sense of self-criticism in relation to traditional acupuncture. One of the clear difficulties students appear to be facing while conducting their enquiry project is the requirement to explore acupuncture in relation to 'isolated' medical conditions. This requirement stands in contrast to acupuncturists' holistic notion of treating the patient's constitution and of treating the interrelations between body, mind and spirit. Students are required to review clinical biomedical research, which tends to isolate treatment and condition, with little or no consideration of the 'whole person'. Clinical trials are standardised in a way that they reduce individual features of individual patients (to reduce bias) rather than to consider each participant's 'individuality' and unique characteristics (Keshet, 2009). In contrast, as discussed previously, traditional acupuncture theories (depending on the style of practice) tend to focus on the individual's unique 'constitution'.

The requirement that students explore both and 'Western' approaches and provide some sort of synthesis of both is indeed a significant challenge to them. Placing isolated medical conditions which are described using biomedical terminology next to the description of the condition within the context of Chinese medicine is a difficult task. One of the students argued in his dissertation that Chinese medicine offers patients a clearer, perhaps more theory-grounded, explanation of the symptoms that they experience. This stands in contrast to biomedicine's perspective of focusing on symptoms and medical conditions in isolation from the broader 'whole person' context.

Some students tried nesting the condition being investigated, and which was described using a biomedical perspective, within the conceptualisation of Chinese medicine. Such explanations create a fascinating patchwork resulting from the effort to place biomedical and Chinese medicine descriptions side by side and even synthesising both. Whatever the value of these efforts in relation to the accuracy of medical knowledge, they appear to promote a critical observation of practice using two very different perspectives.

While reviewing a selection of abstracts of students' enquiry projects, the difficulty they experienced in negotiating technical and indeterminate kinds of knowledge was apparent. It seems as if while some students adopted biomedical research as an integral part of their expert knowledge, others saw it as an alien form of knowledge that does not match the philosophy of Chinese medicine and therefore was an unwelcome addition to their education. On several occasions, when the results of biomedical research did not favour acupuncture, students concluded that this was due to the incompetency of clinical trials to investigate acupuncture as an individualised, holistic form of medicine.

Students Enquiry Skills projects: Several observations

I would like to discuss several observations in relation to students' work on the unit Enquiry Skills, starting with the tensions between the holistic nature and the non biomedical concepts that are part of acupuncture and the drive to increase the teaching of biomedical science and biomedical research in acupuncture courses. These tensions that were evident in my participant observation are central to the process of formalising acupuncture courses. The alignment to the scientific paradigm, the use of RCTs to establish the effectiveness of interventions, and the development of scientific explanatory models, are strategies that are expected from a group engaged in professionalisation (Cant & Sharma, 1996b).The importance of achieving external legitimacy through biomedical alignment is demonstrated by the way that, in the past, the British Medical Association attacked alternative therapies as primitive superstition, or the way that leaders of medical acupuncture warned the public of the danger of consulting NMQ practitioners (Saks, 1999). As pointed out by Welsh et al. (2004), 'in order to meet the necessary criteria, complementary and alternative practitioners must adapt to a more medical model of healthcare than the one to which they have been accustomed' (2004, p.236). As a result of external socio-political pressures, main CAM groups, including acupuncture, have to construct a professional identity that incorporates elements of conventional medicine and the medical model. The danger, Welsh et al. argue, is that CAM practitioners might see the

medical model as synonym to professionalisation (ibid). The tension between the increased emphasis on RCTs on traditional acupuncture, and the therapy's individualistic and holistic nature, was explored by Jackson and Scambler (2007). They describe how NMQ acupuncturists expressed considerable doubt over the value of EBM for acupuncture and the inability of RCTs to capture its holistic nature. Practitioners in this study perceived EBM as 'a game' that they had to play which is dominated by biomedicine. At the same time, their own clinical experience was sufficient evidence that acupuncture 'works'. Moreover, practitioners appealed to charismatic authorities in acupuncture such as Worsley, Van Buren, Maciocia and others, and saw their work as more significant than biomedical research in guiding their work. In studying the views of leaders of traditional acupuncture and Chinese medicine in Canada, Welsh et al. (2004) discussed the infusion of biomedical sciences into acupuncture education, as a strategy of demarcating knowledge-claims from internal competitors. Some of the acupuncture/Chinese medicine leaders emphasised the inclusion of anatomy, physiology and other medical sciences in the acupuncture courses' curriculum as necessary, as well as the integration of Chinese medicine philosophy with medical sciences. Here, medical science is seen not only as a tool of achieving a degree of social closure or as a way of increasing external legitimacy, but also as essential in ensuring safe and effective practice (ibid).

For students in my participant observation the use of biomedical research findings was viewed critically, in that it can produce positive, negative or inconclusive results on the effects of acupuncture. These findings were often described without being fully endorsed, often pointing to the lack of suitability of clinical trials to capture the individualistic and holistic nature of acupuncture. At the same time, students did not apply the same critical approach in their discussions of Chinese medicine philosophy and theory. The traditional acupuncture perspective on the research question often lacked critical judgement and was taken for granted as 'the truth', without considering the possibility that this may not be the case. This might point at a certain conflict that the students experience. On one hand, their passion and commitment to the holistic ethos was possibly central to choosing to study acupuncture. At the same time, however, the infusion of biomedical sciences and RCTs into the curriculum signals its importance in ensuring safe and

competent practice. For the school this might present a significant dilemma: how to maintain students' passion for Chinese medicine philosophy and the holistic concepts that are part of it, and not tilting the balance towards the medical model? To a certain degree, my argument is that HE can, paradoxically, support students' reflective approach, encouraging debate over both the nature of their holistic discourse as well as of the role of biomedicine in their training and future practice. From this perspective, formalising education involves not only strategies to achieve external legitimacy, but it can also contribute to extending both the professional and academic orientation of the practitioner in relation to the broad challenges of contemporary healthcare in the same way that other university-based health professions do.

It should be said that students in my participant observation did not always demonstrate such reflectivity. For example, on quite a few occasions during my observation the Chinese medicine perspective on the research question was 'romanticised' and presented as superior to that of biomedicine without establishing a rationale for doing so. Quite often the biomedical angle was presented on the basis of its 'reductionist merits', while Chinese medicine was described on the basis of its 'holistic merits'. Moreover, the term 'holistic' was often attached to Chinese medicine and to the way it addresses the research question, without considering the meaning of holism and without critically examining its role. When I asked presenters what they meant by saying that 'acupuncture is holistic', it seems that the meaning was not considered. It is possible that greater consideration of holism would have assisted students in addressing some of the challenges they face, such as balancing biomedical and Chinese medicine language and negotiating the explanation of isolated symptoms with Chinese medicine philosophy. However, the exercise itself of placing biomedical and non biomedical perspectives side by side may promote the sort of reflective and critical skills that will help students develop an understanding and awareness of the complexities inherent in holism in the context of their practice. This is clearly an emerging process, and how it will drive acupuncture practice only time will tell.

It seems that students were not tuned in to the role of the wider environment of patients. Rarely any mention was made of issues outside the 'inner workings' of the patient, be it using a biomedical or the Chinese medicine explanation. Even in relation to very broad and multi-factorial health concerns such as anxiety, depression, malaria, cancer (as opposed to investigating the effect of acupuncture on more 'localised' symptoms as say 'frozen shoulder') students did not consider the patient's broader environment. Does the challenge of having to consider both traditional acupuncture and biomedical perspectives and negotiate between technical and indeterminate kinds of knowledge pose a problem? In fact, it seems to prompt, at least in some of the students, a critical consideration of this tension. This in itself may prove a valuable attribute in the development of critical, reflective students and practitioners. What is perhaps lacking is a guiding hand, and an open discussion of these issues, lead by the academic team. In an interview that took place prior to this observation, I asked Lisa if the involvement of HEIs in acupuncture education takes something away from the philosophy of Chinese medicine and the holistic premise of acupuncture. Her view perhaps demonstrates her willingness to accept changes and take risks as part of acupuncture's professional project, rather than to protect and defend the 'purity of knowledge' and acupuncture's professional boundaries at all costs. Lisa's vision as the school principal is perhaps best captured in the following quote in which she refers to the validation of the school by a HEI:

> Maybe bits of things getting lost on the way and other things get added. But I am not scared of the process of change. I am not protectionist about Chinese medicine. I'm suppose I am too passionate about it to be a protectionist about it.

Lisa is conscious of the challenges that come along with the movement to a more formal, standardised education, and the difficulty of embedding technical knowledge into traditional acupuncture teaching. Nonetheless she recognises this shift as a needed change, perhaps an unavoidable one, which brings with it new opportunities, and should therefore be embraced by acupuncturists. This is clearly an emerging process which requires time to mature, but the school, from the principal to the lecturers and all the way to the students, are all engaged in efforts to negotiate the challenge. What is clearly occurring is an increasing emergence

of critical awareness of acupuncture knowledge and practice. In the following sections I will return to the data that was gathered from interviews and document analysis, to further explore some of the data from this participant observation in the context of the broader professional project in acupuncture.

6.3 Negotiating challenges involved in the formalisation of education in acupuncture

Professionalisation involves a shift to more formal education structures, including recognised forms of validation and transparent criteria for quality assurance concerning assessment and performance (Sharma, 1996, p. 266). Hence, this process involves a shift from an informal/charismatic form of teaching to more formal/bureaucratic teaching (Cant, 1996). In the following section of this thesis, I will consider the perspective of NMQ acupuncturists, members of the BAcC, their schools and professional body in relation to the formalisation of their educational structures. I will consider the fear of losing the holistic ethos of their practice during the formalisation process, and the impact of HEI validation of acupuncture courses on holism in acupuncture.

One of the difficulties in standardising traditional acupuncture education is the translation of concepts that are a product of Eastern philosophy to a European setting, raising the question of how they are comprehended and understood by students in the West (Cassidy, 2006), let alone how they can be codified and standardised. From the students' perspective, they are required to undergo a journey of acclimatisation to terminology and meanings that are very different to those they are familiar with. This adaptation is not an easy learning journey for acupuncture students, as explained by Lisa in relation to her school. In the following narrative she tried to convey the process that students are going through in their effort to grasp the new language of Chinese medicine. This challenging, often frustrating, learning process starts with what she referred to as 'sitting in ignorance' and accepting that, at least for a while, knowledge appears as foreign and incomprehensible:

> When we designed the curriculum, the idea that we originally had in mind was an idea that I call 'sitting in ignorance'. And I think it goes something like this. If you want to undermine people's concept of the world, which you need to do if you want them to look at a different life philosophy, you need to get them to question their own life philosophy. So first they have to identify it and then they have to be prepared to question it, and that's an extremely uncomfortable place to sit in.
>
> For most people they won't go there because it's outside their 'comfort zone' to use a popular cliché. What we were trying to do when we initially designed the curriculum, was to present people purposely with stuff that they could not understand. You struggle and struggle and you can't, it won't lend itself to rational analysis.
>
> The students have trouble. It's a really hard course. Particularly in the first and second year. In the third year it's all falling into place. In fact it often flags up in students interviews, especially if they come with a Western medical background, I say to people 'you know, we can only ask you for a conscious suspension of disbelief' to use that phrase. Because if you try to translate this to a framework that you know and understand, it's a bit like trying to learn a foreign language.

Moreover, as a result of the validation process, students face another paradoxical challenge. When they eventually digest the terminology and the philosophy of Chinese medicine, and - as described by Lisa - 'it all falls into place', they are required to re-immerse themselves in biomedical knowledge when they study human biology and biomedical research methods, which are taught on BAcC accredited courses. In 2000 the BAcC published the *Guidelines for Acupuncture Education* (2000) which was produced by the BAcC Educational Policy Committee in consultation with the accredited acupuncture schools. The document presented requirements and recommendation on acupuncture education for the schools that are members of the BAcC. In line with recommendations made by the House of Lords Select Committee (2000), the document guided all accredited courses to teach research skills to ensure that students are able to critically consider published research and 'understand the link between research and practice':

> 5.3 Research and reflective practice: Students should be able to make a critical analysis and evaluation of existing research. Students should know and understand a full range of approaches appropriate to acupuncture.

> Students should be aware of the benefits of research in developing good practice and promoting acupuncture more widely. By the end of the course, students should have had direct experience of reflective practice, and clearly understand the links between research and practice. Students should be able to utilise a range of research strategies for improving personal and professional standards in the practice of acupuncture (British Acupuncture Council, 2000).

Ten years after the publication of the *Guidelines for Acupuncture Education*, the British Acupuncture Accreditation Board (BAAB), the accreditation arm of the BAcC, published its accreditation handbook (British Acupuncture Accreditation Board, 2010). This extensive and detailed handbook provides guidelines on the accreditation policies and procedures of the BAAB. In its introduction to 'principles and values for acupuncture education' the document tries to settle the relationships between the artistic and scientific sides of acupuncture practice in the context of courses' accreditation and validation. Identifying the unique constitution of the patient or promoting the patient's own healing capacities involves the utilisation of an indeterminate knowledge base and skills, such as balancing the patient's *qi*. Indeed, the document describes acupuncture as rooted in 'the art of practice' which is creative in nature. At the same time, the document points out the need of the profession to be responsive and adaptable to the broad professional environment in which acupuncturists operate, and, as part of the professional project of acupuncture, embed knowledge of scientific research into the curriculum:

> Acupuncture education aims to be: ... practice-led, rooted in the artistry and science of acupuncture as an empirical and practical professional activity informed by theory and creative of theory, and recognising that, as acupuncture is a practice-based profession.
> [Acupuncture education aims to be] responsive, capable of adapting to changing healthcare needs and perceptions and to the evolving criteria and expectations of the profession, making full use of research findings to inform curriculum design, delivery and evaluation (British Acupuncture Accreditation Board, 2010, p. 13).

The BAcC placed a recommendation that acupuncture courses should be taught at honours degree level (ibid, p. 9). Moreover, it places an expectation that the course teaching team is made up of qualified teachers who are research active

and research literate at higher education level (ibid, p. 16). Without exception, all BAcC accredited courses devote a considerable part of their curriculum to the teaching of scientific research. For example one college highlights the link between HEIs', professional standards and the research focus that are part of their courses:

> As an educational and training institution working both at the level of higher education and within the profession of Acupuncture, the College incorporates research-mindedness into much of its programme.
>
> The intellectual skills of criticality, scientific enquiry and reflective practice are supported by our research modules, which aim to introduce students to the main principles of research methodology, strengthening students' ability to source information for them and to evaluate it effectively.

At the same time BAcC courses do not hide the difficulty of teaching biomedical research concepts alongside esoteric, 'traditional', non biomedical knowledge. The school promotes the teaching of scientific research, but recognises the difficulty of teaching biomedical research as part of the 'world of acupuncture'. It is argued that this mixing of both kinds of knowledge will contribute to the future development of acupuncture:

> The challenges of applying western style research techniques to the world of acupuncture and Chinese medicine are explored. ... Preparing and encouraging students to carry out effective future research, as qualified and registered acupuncture practitioners, will contribute to the research base and development of the profession as a whole.

Another acupuncture school also made a clear commitment on its website to improving acupuncturists' engagement with scientific research as part of the professions' future development. This school, too, did not hide the tension between biomedical research and acupuncture philosophy. Nevertheless the school encourages acupuncturists to engage in such research, and ensure that it represents the nature and ethos of acupuncture practice:

> We at [name of school] believe that acupuncturists need to engage with research; by this we mean as a minimum to be able to understand research and how it does and does not inform our practice.
>
> Acupuncture is a complex intervention, often diluted to its detriment in research, particularly that which reaches the headlines. We must, as a profession, seek to produce research - and disseminate it - that better informs both our practice and external stakeholders.
>
> If we bury our heads in the sand and shake our heads from the sidelines, poor quality and irrelevant research will continue to be carried out in our name.

Another acupuncture school highlights on its website the importance of integrating biomedical sciences with Chinese medicine philosophy while emphasising the validation and accreditation benefits that are attached to this integration:

> At [name of school] we integrate East with West so that our students learn Western medical sciences alongside Chinese medicine theory, including the well-known approaches of TCM and Five Elements. Our postgraduate and undergraduate courses are fully validated and accredited, degree level, and are tailored to suit those of you with no previous experience as well as healthcare practitioners from all systems of medicine.

Handing control over knowledge transmission to external agencies such as HEIs enhances acupuncturists' external legitimacy. In contrast, this process potentially involves, at least to a degree, the loss of autonomy over practice. While acupuncture schools recognise the professional benefits and increased status that comes along with professional accreditation and HEI validation, there are significant challenges involved in formalising education of knowledge which has component high I/T ratio. For example, how is such knowledge codified, standardised, and 'quality assured', considering the artistic, intuitive nature of acupuncture. In the next section I will more closely focus on the challenge of formalising esoteric knowledge.

6.4 The challenge of formalising esoteric knowledge in acupuncture

While discussing the challenge of standardising esoteric aspects of acupuncture training, Marylin, a senior lecturer on a BSc (Hons) Acupuncture, describes how students on her course learn to 'feel *qi*' during their training. Such skill is difficult, if not impossible, to codify:

> The lesson I teach is called '*qi* practice' so they learn to feel the *qi* and to do exercises and they are encouraged to 'take *qi*' and to empty themselves and to feel it more. ... This is the most difficult thing that the students have to do, because they are so stressed and they are so reliant on books.

In its *Guidelines for Acupuncture Education* the BAcC tried reconciling quality assurance and standardisation procedures with the holistic and the esoteric concepts that are central to Chinese medicine philosophy, theory and practice. Some of the professional values stated in the document are difficult to codify and assess, such as 'compassion', being able to 'offer the possibility for (re)discovering what it might mean to be fully oneself', maintaining 'awareness of rhythm, flow, balance, harmony and resonance', or 'the development of the practitioner's artistry and the patient's self-awareness':

> Statement of professional values: The practice of acupuncture is informed by values and principles which include the following.
>
> It seeks to be: ... *Compassionate* - an approach that brings sensitivity, empathy, humility and compassion to the therapeutic relationship.
>
> *Holistic* - because treatment is based on an understanding that mind, body and spirit are integral, acupuncture can offer the possibility for (re)discovering what it might mean to be fully oneself.
>
> *Dynamic* - an awareness of rhythm, flow, balance, harmony and resonance, and the ways that changes in seasons and cycles of life inform both diagnosis and treatment.
>
> *Creative* – every therapeutic encounter brings with it the potential for a fresh and creative response and for the development of the practitioner's artistry and the patient's self-awareness [emphases in original] (British Acupuncture Council, 2000, p. 5).

Over a decade later, in 2011, the BAcC published its *Standards of Education and Training for Acupuncture* document which set 'the educational outcomes required for meeting the entry standards necessary for professional membership of the BAcC' (British Acupuncture Council, 2011, p. 5). This document, which replaced the *Guidelines for Acupuncture Education,* was a move further away from the rather informal description of practice to a tighter and more formal description of practice outcomes. Several fluid professional values such as compassionate, dynamic and creative were taken out, and more formal professional qualities were retained, including patient-centred, competent, safe, ethical, reflective, and culturally competent. The new document did maintain the emphasis on the artistic nature of acupuncture practice, but in a more subtle manner. In relation to the professional value 'patient centred', the document highlights the need to consider both science and tradition:

> Drawing on acupuncture's roots in both science and tradition, practitioners are committed to providing effective treatments with successful outcomes (British Acupuncture Council, 2011).

The recognition of the creativity of practice is maintained under the professional value 'competent':

> Practitioners understand that acupuncture evolves and develops from a synthesis of theory and practice, where practice is both informed by theory and creative of it (ibid).

In relation to holism as a professional value, the authors tried amalgamating several holistic elements, including a) taking into account the patient's physical, mental and emotional condition, b) considering the patient's lifestyle, c) seeing body, mind and spirit as interrelated, and e) the resonation of a human being with the natural environment:

> Holistic: Practitioners take into account a patient's physical, mental and emotional condition and lifestyle, based on an understanding that body, mind and spirit are integrated and an acknowledgement of the resonance of human beings with the natural world (ibid).

The Standards of Education and Training for Acupuncture is a comprehensive and detailed document, guiding the teaching of acupuncture. It provides guidelines in relation to diagnosis and treatment, communication and interactions, safety, professional development and business management. The document maps learning objectives and learning outcomes, including in relation to 'highly indeterminate' practice skills, in a way that formalises what are in essence un-standardised skills. For example, in relation to diagnosis and treatment, students are expected, on graduation, to:

> Carry out treatments according to principles of *the flow of qi in the channels.*
>
> Students are expected to be able to. ... 'Safely, effectively and sensibly demonstrate all aspects of needling' (ibid, p. 13).

These skills, it is further specified in the document, involve theoretical and practical knowledge of well-defined subjects, including skills such as 'exercise for developing finger force and directing *qi*' or understanding 'de *qi*'[40] and how to feel for it and search for it'. Many of the skills and learning outcomes are energetic in nature, for example, graduates are expected to be able to:

> Formulate a treatment strategy, treatment plan and method of treatment that meets the specific needs of each patient and aims to harmonise their *qi* (ibid, p. 12).

In order to meet this learning outcome students are required to be able to demonstrate treatment methods which involve the manipulation of *qi*, such as to 'clear heat', to 'drain dump' and to 'treat emptiness [of *qi*] with tonification [of *qi*] and excess [of *qi*] with reduction [of *qi*]'. While the document itself is comprehensive and detailed, it does not provide a clear indication of the way that

[40] The term used to describe the sensation of *qi* and feeling the *qi* by the patient once the needle is inserted at the acupuncture point.

such indeterminate knowledge is assessed. An examination of how such highly intuitive skills are assessed within the classroom was beyond the scope of my research and requires further observation and research. My review of school's course information elicited only general information in relation to the assessment strategy of such skills. A typical example is the assessment description in a BSc (Hons) Acupuncture which provides the following information:

> Students learn practical skills through demonstration, observation, doing, feedback, experimentation and role modelling. Students' practical skills are assessed by clinical assessment, laboratory simulations, and examination of clinical skills, report writing and reflection.

It is important to consider that since most of the BAcC acupuncture courses are taught by or in collaboration with HEIs, they are all required to have a certain degree of codification and standardisation. It seems that such standardisation is achieved at the level of indicating what should be the taught knowledge, what should be the course content, and indicating the kind of educational procedures and teaching structures that should be put in place. What I found no evidence of is how indeterminate-related skills such as manipulating qi, identifying the energetic constitution of a person, or feeling the energetic nature of the patient's pulses, all of which require a degree of experience, intuition and artistry, are codified, 'tested' for, and assessed against. For instance, reading the patient's pulses is a significant part of the diagnosis procedure in traditional acupuncture. Chinese medicine recognises 12 pulses which correspond to the inner organs and which resonates the patient's energetic balance/imbalance. For example, a 'tight pulse' may indicate 'access heat' while a 'hasty' pulse may indicate 'extreme heat' (Fulder, 1996, p. 129). Mastering this technique requires many years of experience and practice to enable the acupuncturist to develop 'a feel' for the technique and recognise the different pulses and their qualities.

Since nearly all acupuncture courses are taught, or accredited by, universities, in the next section of this chapter I will consider the impact of HEIs on the formalisation of expert knowledge, and, in particular, on acupuncturists' holistic discourse.

6.5 HEIs' validation of acupuncture courses and the fear of losing the holistic ethos of education and practice

As discussed in Chapter Three, since the mid-1990s, an increasing number of acupuncture courses have come to be taught or validated by British universities. In this section I will discuss the perspective of acupuncture school principals and of NMQ acupuncturists in relation to the validation of their courses by HEIs, including the fear of losing the holistic ethos of practice as part of this process.

The three acupuncture school principals that I interviewed, Nicola, Lisa and Jeannette, took an active role in the university validation of their courses. All three were keen to highlight the fact that although their schools compete with one another over students' market share, they regularly meet up to discuss mutual concerns in relation to acupuncture education. All three described their initial concern that the formal nature of university validation will lead to a loss of both the holistic nature of their knowledge and the informal character of their courses' delivery. However, all three perceive the process as worthwhile, albeit challenging, as Jeannette describes:

> In 2002 we were validated by [name of] University with a BSc Honours degree, and that was a big challenge. The big challenge was to keep the course and the important parts of the course and at the same time make sure that we brought in everything that was needed for a degree level course. We have crossed that bridge a long time ago now and everything is kind of smooth with that.

Nicola also recalls her initial anxiety and the worry of losing some of the essential elements of Chinese medicine philosophy when her school entered the academic validation process:

> When we started with the accreditation process I thought we were sending ourselves down the drain. We had a common denominator which was much lower than I hoped it would be, but we have to start somewhere, yeah. So I just felt 'that's where we start', OK. But I've never lost sight of where the college should go. And then anybody who chooses to study in our college, ok, then I can give them what I think is necessary.

Lisa is the principal of the school where I carried out my participant observation. Impressed by the warm, friendly and rather informal atmosphere in her school, I asked her if, like other school principals, she was not concerned that during the HEI validation process these attributes would be taken away. She answered in a rather philosophical manner, in a way which suggests that this process is part of the natural evolvement of acupuncture's professional development:

> I suppose that one of the things about coming at the beginning of something much like I did is that you learn to adapt and to change … and my view isn't necessarily the view of my students for example, and some of them will think completely different from me, and that's completely fine by me. I'm completely accepting that. I don't think you can say that any change [i.e. the academic validation] 'takes away' [the philosophy of acupuncture] anything. I think you can say that 'it makes it different'.

In fact, all of the university-validated acupuncture schools proudly present the academic status of their courses on their website. Moreover, they use it as a marketing tool to attract students, as an indication of delivering high quality education. For example, one of the other acupuncture schools is stating on its website that:

> Our acupuncture courses are validated by [name] University. This means you can be assured that the quality of the education you will receive is the same as a University course, and you will receive a [name] University degree at the end of your studies.

All BAcC acupuncturists participating in this study supported HEI validation of acupuncture courses. However, this is not to suggest that there is no opposition to this process within acupuncture. It is possible that acupuncturists who oppose the academic validation of their courses did not want to engage in this research. But those practitioners who took part in this study highlighted the potential benefits that arise from HEI validation. Sue, for example, argues that this process is a step forward, that it increases the professional profile and status of acupuncture. In her view it does not damage the holistic nature of acupuncture:

> Personally I love it [academic validation]. I do see it as a great step forward. I feel that we, if we're ever going to be taken seriously, we have to step up to the mark, we have to get ourselves good degrees and be able to present ourselves in a way that Western medicine can accept and I think that's beginning to happen.
>
> What excites me about that is that if people want to work in the NHS there then will be opportunities for clinical audit and research and that will hopefully move forward. *So I love it, I don't feel we lose our mystique*, personally, I think *we want to be taken seriously* and I think it offers more opportunities to the students of acupuncture because they are more opportunities for research or for teaching at a higher level if you like, so it opens their world up a little bit and *I don't think we have to lose anything by that*, I'm sure other people will disagree but, I think we can maintain what we have. [My emphases]

Alan was trained before the academic validation of his course was put in place; hence, he did not obtain an academic degree. Still, he too supports HEI validation, suggesting that it provides acupuncture with a well needed sense of self-criticism that the profession currently lacks:

> I think it's very important in any discipline to apply self-criticism and what I observed when I was training 6 or 7 years ago was that there was insufficient self-criticism and I expect that now that the Chinese medicine colleges in the UK are gradually adopting academic methods through their association with universities, I fully expect that the sort of self-criticism that is necessary, and debates and interaction with opposing points of view, or different points of view, the benefits for that I see as being potentially enormous.

Whilst recalling the challenges, Jeannette reflects on the journey of validating her school's acupuncture course as a successful operation. She mainly refers to what she considers to be managing to bring acupuncture training into academia without losing the core philosophical elements of Chinese medicine or the ethos of 'treating the whole person':

> I think that we've dealt with it [validation] quite well here; I think that if we are pressured into having an evidence base for every single thing then what we don't want to do is cut out the beauty of Chinese medicine.
>
> Chinese medicine has been around for so long and you know, I wouldn't want us to just turn into medical acupuncture which has obviously got a

> strong evidence base and there is a lot of evidence for all kinds of acupuncture, but I think that the teaching of that [core philosophy] has to remain and at the moment obviously that is something that we have felt that we've been able to keep - the core of what we do, which is treating the whole person, in place.
>
> And that is really important for us, and we haven't found that a difficulty, we've got quite a strong research component to the course, but we've also got a strong ethos about that [which] we teach, about treating the whole person, so that is big and we want to make sure that remains.

Overall it is appears as if the initial concern of losing the holistic ethos of acupuncture practice in the course of HEI validation, as well as the concern over the formal nature of the process, have been overcome by the professional and academic benefits that come with HEI validation. Nevertheless, it is important to consider this process more critically, in the context of broader societal and political influences in CAM and as part of the conceptual threads presented in Chapter Three. The way HE involvement in acupuncture education reflects the tension between increasing practitioners' external legitimacy and their status as safe, responsible, 'informed' practitioners, and the desire to maintain the unique and holistic nature of esoteric knowledge. This will be discussed in length in section 7.7 of this thesis, as part of the analytical discussion of Chapters Six and Seven. It is evident, though, that this process is ongoing and that NMQ acupuncturists are in the midst of the process of negotiating the challenges that are part of it. Moreover, there is evidence that some practitioners are not content with the increased emphasis in HE validated courses on RCTs and with the degree of biomedical alignment in acupuncture training (Jackson & Scambler, 2007). In the final section of this chapter I will consider the relationship between HE validation of acupuncture courses and the holistic discourse.

6.6 HEIs validation and the holistic discourse

In the following section I would like to consider the impact of HEIs' role in the formalisation of acupuncture courses, over acupuncture's holistic ethos and holistic discourse. I argue that there are several significant attributes to HEI involvement in the formalisation of acupuncture education to both the shaping of

acupuncture's holistic discourse as well as to an increased awareness within acupuncture of the sensitivities inherent in some of its holistic claims. I have presented several examples in the data of the way that HEIs promote critical thinking and self reflection amongst students. Developing such critical awareness and reflectivity towards one's practice may prompt a drive amongst acupuncture students to critically consider their own discourses, the nature of their professional knowledge, as well as the nature of biomedical knowledge in the context of contemporary acupuncture practice. This injection of a self-critique culture may change what is currently a growing sense of frustration with what some perceive as an 'empty' holistic discourse. Moreover, the teaching of acupuncture courses within universities is taking place alongside other disciplines and professional groups. In 2010, BSc (Hons) Acupuncture courses were taught at universities in the following departments:

- Faculty of Health & Social Care; School of Community, Health Sciences & Social Care
- School of Health & Social Sciences
- School of Life Sciences
- School of Health & Social care
- School of Health, Sports & Biosciences
- Faculty of Health & Social Sciences
- Faculty of Health, Psychology & Social Care
- Faculty of Health & Social Care, Department of Allied Health Sciences

The teaching of acupuncture as part of the above academic subjects points at an intriguing development. While undergraduate acupuncture courses increase the teaching of biomedical knowledge and research in their curricula, with the exception of two institutions, the courses are placed outside the 'strictly biomedical' domain. This is not an unusual phenomenon, and whiles 'health sciences' is a rather broad title, which might include an array of subjects, quite

often allied to health professions are placed in such academic departments. What is clear though, is that acupuncture as an undergraduate course is often positioned alongside allied to health and care professions including nursing, social work, radiography, operating department practice, occupational therapy and physiotherapy. In one of the universities acupuncture is taught alongside Public Health and in another alongside psychology. Such interaction may lead to an improved understanding of inter-professional collaboration and a greater reflective awareness of the broader health environment in which practitioners operate. This development should be seen as a two-way stream. Being taught in HE increases acupuncture's external legitimacy by a major mainstream institution, which rewards the formalisation of education and the biomedical alignment that is part of it, while being taught alongside other healthcare professions and other academic disciplines. At the same time, this is an opportunity for 'externals', including academics and professionals from other disciplines, to get to know acupuncture within the confines of HE, as a 'respected discipline' rather than as an exotic practice in the CAM domain.

The fact that in some of the universities acupuncture is taught within health sciences and in (the minority of cases) biomedical departments, may lead to a change in the antagonistic attitude towards biomedicine that I witnessed in my participant observation. It may lead to a more balanced, yet critical, consideration of mainstream health provision and of biomedical health provision. The aforementioned developments can be seen as increasing the scope of acupuncture's holistic discourse, mainly in relation to matters of wider world holism. The fact that six of the BSc (Hons) Acupuncture courses are taught within faculties or schools for health and social sciences may contribute to a growing awareness and reflectivity over sociological concerns surrounding acupuncture, which, subsequently, may lead to the development of a wider world holism. For example, one of the BSc (Hons) Acupuncture courses has units entitled 'The Sociology of Health' as well as 'Concepts of Inter-professional Practice in Health and Social Care'. One of the learning outcomes of the course run by another university-based course is 'an appreciation and understanding of the major debates in health care with particular reference to concerns in [name of city]'. The course at another University specifies in its Research Methods unit the teaching of

‘approaches to health and social care research’ while the same unit at another university teaches social science research as part of the acupuncture course:

> Students will consider different approaches to qualitative research, such as ethnography, phenomenology, and grounded theory. The module will enable students to consider ways in which research data are collected and analysed using observation, interviewing and questionnaire techniques.

An interesting example is that of another university-based BSc (Hons) Acupuncture. The course handbook for 2011/12 provides an example of the way that the university environment can influence the holistic discourse in acupuncture education. The course information links the teaching of acupuncture with other academic disciplines:

> This Course aims to provide a progressive and cohesive route of applied learning, enabling you to understand the relationship between Biology plus elements of Psychology and Sociology and Medical Science, and apply this knowledge to Acupuncture practice

While the course information points to the integration of technical knowledge into the course syllabus, at the same time the holistic premise of acupuncture is not forgotten:

> Whichever style of treatment is chosen [traditional or medicalised], acupuncture treatment harnesses the body’s ability to self heal and has its strengths in the unique way in which patients are holistically assessed and managed. ... The body is a unit; it has its own self-protecting and regulating mechanisms.

What is intriguing is how these holistic concepts can be assessed in the same way as other professional skills are assessed in a university setting. While the course information does not discuss exactly how this is done, it does suggest that by integrating the aforementioned academic disciplines into the acupuncture curriculum, students are gaining sound higher education which enables them to assess accurately holistic needs of their patients. The following quotes are taken from the description of the course’s learning outcomes:

> To provide a sound higher education in the theory and practice of acupuncture; To enable students to acquire a wide range of skills appropriate to the major area of practice, including being able to assess accurately the holistic needs of patients;
>
> To provide a progressive programme of study that enable[s] students to achieve a holistic approach which embraces all of the disciplines that inform an understanding of Acupuncture.
>
> To enable students to communicate effectively with patients and the inter-professional team ... To demonstrate the ability to integrate the knowledge base from different disciplines to promote innovative solutions to problems and dilemmas in Acupuncture.

At the same time, it should be noted that this particular course has far higher biomedical content than courses at any of the private schools, and significantly less traditional acupuncture content. This may be seen as reaffirming the fears practitioners expressed of losing the indeterminate nature of acupuncture. For example, during the first year of study, only one out of six units was dedicated to acupuncture theory while three units were biomedical in nature. Such a high biomedicine/acupuncture ratio in favour of biomedicine on BAcC accredited courses is, however, unusual, whether the course is taught within a university or by a private school. The university based courses all maintain rather similar course content to that taught by the private schools, with a clear emphasis on acupuncture theory and practice.

While there are signs of an increased awareness of wider world holism on the university taught acupuncture courses, I did not come across a similar development in the information I gathered from the private acupuncture schools. Having said that, it is important to bear in mind that acupuncture educators from both private schools and university-based courses interact through professional and academic channels such as conferences and CPD events. Therefore it is likely that there is certain ‘cross-pollination’ of experiences and ideas between lecturers at the private schools and the lecturers on the university based courses. Hence it is very possible that such wider world awareness will also flourish in years to come in the private schools. Perhaps what we are witnessing is somewhat paradoxical: on the one hand a movement from informal to formal education structures, and increased biomedical input in acupuncture education

which can be considered as decreasing the holistic ideology of practice. At the same time, we may be seeing a significant development in acupuncture's holistic discourse. The academic engagement with HEIs is increasing the holistic scope of acupuncture by increasing students' critical awareness of holism and with it an increased interaction with other academic and professional perspectives, broadening the current holistic scope. Moreover, at least in the case of courses that are delivered within universities, it is possible that the biomedical alignment is paralleled by the students' increasing awareness and reflectivity over the broad environment. It is possible that, in the case of NMQ acupuncture education, we are witnessing the beginning of a 'wider world holistic alignment' next to the biomedical alignment.

In this chapter I discussed the case of acupuncture. In the next chapter, I will examine data in relation to the formalisation of homeopathy education and its impact on homeopathy's holistic discourse. In the final part of the next chapter I will discuss the findings from both Chapters Six and Seven.

Chapter 7

Negotiating content and context of knowledge in homeopathy: Formalising education while guarding holistic claims

In Chapter Six I discussed the way that NMQ acupuncturists negotiate their holistic premise during the formalisation of their educational structures, and how, in return, the process of formalising education, and in particular HE involvement in that process, influences the holistic discourse in acupuncture. In this chapter I will consider this process in relation to NMQ homeopaths. The data in this chapter builds on interviews with homeopathic practitioners, homeopathy courses' information obtained from 13 SoH accredited schools in the UK, and SoH educational and practice documents.

I should point out in advance that my findings in relation to the perspectives of the homeopathic schools and with them in relation to HE, were somewhat limited by two factors. First, the closure of university homeopathy courses in the past three years has left at present only one BSc (Hons) Homeopathy course and one (only recently opened) distance-learning MSc Homeopathy. Second, possibly due to the sense of distrust deriving from the frequent attacks on homeopathy by sections of academia, the government and the media, I found it difficult to recruit homeopathic practitioners to the research study. I was also unable to set up a participant observation in one of homeopathic schools in the same way as I did in acupuncture. Arguably, such hesitancy and reluctance to participate in the research is not surprising considering the history and culture of NMQ homeopaths. There are a number of factors which have influenced the nature of homeopathy practice and homeopaths' proffesionalisation strategies in the past three decades or so, which I will discuss in the following section. In order to contextualise the empirical data in this chapter I will examine the nature of professionalsiation strategies in homeopathy, including formalising education, and the tensions inherent in these strategies. These developments exceeded the entrance of homeopathic courses to higher education, but included efforts by SoH to standardise education, define the professional borders of homeopathy, and

establish a degree of exclusivity in relation to other professions, medical homeopaths, ‘untrained’ homeopaths and the public.

7.1 Professionalisation strategies and hesitations in homeopathy: an overview

In order to examine the current developments of formalising education by NMQ homeopaths in England it is important to consider the historical context and the roots for the process in the 1970s. At that time homeopathy was taught by a small number of interested students in the homes of charismatic teachers, and was envisaged as a radical social movement which would eventually take over from allopathic medicine (Cant & Sharma, 1995). When the Society of Homeopaths was established in 1978 (Nicholls et al., 2005) it already had around 350 registered members (Cant & Sharma, 1995). A change in the political climate led to mounting external pressure to professionalise homeopathy. The medical profession changed its position towards CAM from near complete rejection to recognition and controlled incorporation of CAM (Saks, 2003b), yet demanding that CAM knowledge would be scientifically scrutinised and would contain medical science, thus ensuring that medicine retains its authority (Cant & Sharma, 1995). In light of CAM’s increasing popularity, the government called for the organisation of CAM, which, in a way, reached a climax in the Lords’ Sixth report (2000). Moreover, consumers called for improved CAM training and standardisation of practice (Cant & Sharma, 1995). From within NMQ homeopaths there was an increasing recognition that there is a need to establish professional boundaries for practice, through some formalisation of training in order to separate between qualified practitioners and untrained ones. Moreover, there was a concern that NMQ homeopaths need to distinguish themselves from medically qualified ones and differentiate their pool of knowledge from that of medical homeopaths (ibid). These internal and external pressures led NMQ homeopaths to embark on a number of professionalsiation strategies.

In their discussion of professionalisation of CAM in the UK, Cant and Sharma (1996b) outlined a number of strategies that are expected from a group that is engaged in this process: a) unification of the group and an agreement about its professional identity; b) codification of knowledge and construction of training programs; c) a degree of social closure and limiting of the number of practitioners belonging to the group by establishing strict training programs which lead to the establishment of exclusivity; d) alignment to the scientific paradigm, using RCTs and developing scientific explanatory models; and e) support from the medical elite (i.e. the medical profession). Indeed, NMQ homeopaths adopted professional strategies on a number of fields, including the establishment of code of ethics, disciplinary procedures, insurance of practitioners and a register (Cant & Sharma, 1995), denoting credible and legitimate practitioners. The society brought homeopathic schools together to discuss education and has tried to initiate changes on homeopathy courses' content and take control over the organisation homeopathy training. Cant and Sharma (1996b) suggested that by approving courses that met their criteria the society achieved agreement about a core curriculum and the professional definition of homeopathy – i.e. what kind of knowledge and practice should a homeopathic practitioner acquire.

At the same time, homeopaths feared that by formalising and standardising their education they will lose their 'idealism' as a holistic movement, as well as their sense of community and the ethos of cooperation and mutual support, in light of increased competition in a more formal marketplace (Sharma, 1996). Another tension was in relation to the scope of homeopathy practice. On the one hand there was an appreciation that the representation of homeopathy as being able to treat all illnesses would be seen unfavourably by the medical profession, and that this would damage the success of professionalising. Therefore, while not necessarily committing themselves to RCTs, NMQ homeopaths demonstrated commitment to research and to looking for the right method to study homeopathy's practical effectiveness. Moreover, despite the critique of RCTs, in 1983 SoH established a research group to develop RCTs on homeopathic remedies, to study homeopathy in relation to specific conditions (Cant & Sharma, 1995). By that homeopathy took a position as 'complementary' rather than 'alternative' medicine. This approach however was seen by many as 'intrinsically

unhomeopathically' (ibid, p.755), since the treatment of patients and not illnesses is fundamental to homeopathic philosophy. Concerns were raised by homeopaths over the suitability of such research to examine an 'individualistic', constitutional approach like homeopathy, a debate that is ongoing (Barry, 2006). Elsewhere, in Ontario Canada, leaders of NMQ homeopaths were also divided over the role of peer-reviewed research in demonstrating the efficacy and safety of their practice (Welsh et al., 2004). While some saw RCTs as vital for increased recognition and the development of homeopathy, others saw RCTs as unsuitable to capture the nature of their practice.

The issue of 'standardisation' was seen as problematic not only in relation to research, but also in relation to standardising homeopathy courses. Cant and Sharma (1995) describe concerns expressed by NMQ homeopaths that homeopathy 'is not about standardisation', due to its inherent artistic and highly indeterminate nature, and that a standard curriculum will represent a lower denominator. Clearly, next to the rewards of professionalism, there were significant dilemmas in these developments, and what was seen by many homeopaths as compromising their philosophy and practices:

> In particular, many aspects of the homeopathic philosophy and mode of practice have been jettisoned in what has, in effect, been a bargaining strategy with the state and orthodox medical profession (Cant & Sharma, 1995, p.744).

Central to homeopaths' concern was the fear of the loss of holism that is fundamental to homeopathy, and the fear that moving to more formal structures and into more mainstream settings (including the NHS), will restrain practice. Cant and Sharma (1996b) suggest that while these strategies have enabled homeopaths to make claims for expertise and legitimacy by adopting the 'traits' of a profession, NMQ homeopaths did not acquire a position of autonomy and monopoly. Overall, homeopaths appeared to be doing 'the right things' to ensure that they are able to maintain their practice, responding to a changing environment, but this was done rather reluctantly, leading Cant and Sharma (1995) to describe homeopaths as 'the reluctant profession'.

Witz (1992) emphasises, that, in order to achieve social closure, it is important to develop clear boundaries around the knowledge that should be acquired by those who are certified as members of the professional group. Developing such boundaries requires group cohesion (Kelner at al., 2006) and an agreement about its professional identity (Cant & Sharma, 1996b). Nevertheless, SoH's drive to develop a core curriculum to homeopathy was not welcomed by all, and it did not quite stop the inner-division over the nature of homeopathic knowledge that was part of charismatic teaching (ibid). This lack of group cohesion in homeopathy was also noted by Kelner at al. (2006) in the Canadian context. In their study, too, the division between homeopathic colleges and professional association limited homeopaths' ability to define their scope of practice and with it to achieve social closure. In comparing homeopaths with the chiropractors' professionalisation efforts, the researchers commented:

> The homeopaths, in comparison, have been unable to reconcile their differences and are still divided into competing camps. The conflict-ridden nature of this group presents a serious barrier to their ability to gather resources and centralize their efforts to professionalise (Kelner et al., 206, p.2624).

On the one hand, Cant and Sharma (1995) argue, the way that SoH transformed its organisation and training in relatively short time is remarkable. At the same time, however, the society was struggling to bring the various individualistic teachers and their schools together. Moreover, the strategies enacted by SoH were 'defensive' in nature; something that had to be done to enable the future of homeopathy as opposed to an enthusiastic engagement in professionalism. To protect their right to practice, homeopaths had to temper their claims and increase bureaucracy (ibid). They have utilised closure strategies and (to a degree) credentialism, and worked towards occupational development and recognition, but were unable to convince all sections of homeopathy that this route is worthwhile. Cant and Sharma concluded that 'the homeopaths are being conveyed along a route of occupational development which they see as inevitable, but they are doing so reluctantly' (Cant & Sharma, 1995, p.759). Perhaps, then, it is not surprising that I found it difficult to engage homeopathic practitioners and

educators in this research study. It might represents a concern of being persecuted, but also confusion in relation to the current status of homeopathy, of homeopathic knowledge, and a hesitation in relation to the process of formalising education. In the followings sections, I will examine the tensions between the holistic philosophy of homeopathy, and the process of formalising and standardising homeopathy education, and the way that these tensions are negotiated today, more than two decades since the process started.

7.2 The challenge of formalising education: the intuitive nature of homeopathic prescribing

In this chapter I will re-visit some of the challenges that were described by Cant and Sharma in relation to the formalisation of NMQ homeopaths' education, and in particular in relation to the therapy's holistic ethos. I will consider the divided views amongst NMQ homeopaths in relation to the formalisation of education and the degree of HEIs interference in that process, which was not present prior to the mid-1990s. I will discuss the diversity of practice and theoretical approaches that are taught by the different homeopathy schools and its impact on the formalisation efforts, and I will re-visit schools' concerns about losing their holistic ethos and their control over the content and delivery of expert knowledge.

As in acupuncture, since the mid-1990s homeopathy has entered into collaboration with HEIs in relation to the external validation of homeopathy education. In contrast to acupuncture, however, this collaboration, which peaked towards 2005, has declined in recent years. Nevertheless, as we shall see, the SoH uses HE standards as baseline criteria for their educational guidelines. This involves, as in other HE taught healthcare courses, putting in place formal structures to ensure quality assurance. One of the clear difficulties present in formal educational documents in relation to homeopathic expert knowledge, as in acupuncture, is that it is often based on the intuition and 'craftsmanship' of the practitioner, rather than on codified, measurable skills (Clarke et al., 2004, p. 335). Cant and Sharma argue that the knowledge of prescribing the homeopathic

remedy is the 'boundary marker between the lay person and the homeopath' (1995, p.746). Gale suggests that as a result of 'a massive range of potentially relevant aspects of the patient's experience', the student homeopaths 'must learn to be comfortable with the *uncertainty* inherent in their case taking and *flexible* in their approach to treatment' [emphases in original] (Gale, 2011, p. 244). For example, Ruth, who graduated in 2001 as a classical homeopath and works in her private practice, describes the creative, intuitive, artistic nature of the prescribing process:

> You know, they say homeopathy is an art and a science. I think that is the more, the artistic, creative side of it in that you have to kind of let it evolve a bit. Try and gauge from the person whether you need to tap into it. There is a lot of intuition in the case taking and that's really hard to explain but sometimes odd things happen in that I'd feel I need to ask that question, and the minute I've asked it I know. It's like hitting the nail on the head, because I've touched on something that is massive and fairly pertinent to why they're here.

Note in the next quote how Ruth often refers to the way she 'feels' that she had to act in a certain way in relation to the homeopathic interview and in relation to the way she prescribes the homeopathic remedy:

> You have set questions to ask. But sometimes *I just felt* I had to ask an odd question. For example with one lady *I felt I just had to ask her* exactly where she lived and she lived right by the sea and then *I felt I had to ask* her about the sea and it was just in between all the other questions. It turned out that the sea was of great significance to her and her family. There was a great tragedy at sea, and it was a really big part of the case. And it's things like that that seems to happen and I can't explain why I asked those questions but they do happen quite often.

For many years, this artistic, intuitive nature of homeopathy's expert knowledge was at the centre of attacks on CAM by a group of academics, scientists, and politicians, often supported by the media. It seems that these attacks intensified in recent years in relation to two issues: the first, the House of Commons 'homeopathy evidence check', was a rather sudden investigation, antagonistic to homeopathy (to say the least), of the provision of homeopathy in the NHS, including the funding of the four homeopathic hospitals (House of Commons Science & Technology Committee, 2010). The second issue was an on-going and

concentrated effort by a group of academics and scientists, supported by the written media, to dispute the provision of CAM academic courses (Corbyn, 2008), arguing that 'unscientific disciplines' are not worthy of being taught at HEIs. Homeopaths in this research study often highlighted what they perceived as an 'anti-CAM smear campaign', and were rather pessimistic in relation to the future of their profession as a result. Like several other homeopaths, Ruth was hesitant when I approached her for an interview. She was concerned with the way that researchers and academics describe homeopathy, often focusing on its unscientific nature. Such description, she believes, is damaging the image of the profession. During our second interview she told me:

> Well, for me it's an intuitive thing [prescribing homeopathy] and I really hesitate, you know [to describe the intuitive aspect of practice] ... I know I didn't say that last time you came and I hesitate to say that really just because for homeopathy to have a conventionally good image it's got to be, certainly in the UK, 'straight down the line', factual. And once you start getting a bit 'airy-fairy' and 'off the wall' with it, you're in dangerous territory.

Homeopaths, also, had to find a balance between the establishment of clear formal standard criteria of knowledge which clearly defines the boundary of the profession, providing it with credibility and separating competent practitioners from unqualified ones, while maintaining the holistic premise of the profession. As with acupuncture, the SoH had to consider the diversity of theories and practical approaches taught at the different schools. I will discuss the way this challenge was approached by the SoH in the next section.

7.3 The challenge of formalising education while maintaining the unique ethos of each school

In 2006 the SoH introduced an education policy which advocated higher education standards as a baseline for homeopathy courses. This policy was aimed at aligning the standards of practice with those of other mainstream health professions (Society of Homeopaths, 2006). It highlighted the importance of education and of quality assurance mechanisms in education as central to achieving regulation and professional accountability in homeopathy practice. The

policy recognises (ibid, p. 5) that course validation by a university (or other validating agency) concerns the intellectual challenge demanded by the course, while the SoH accreditation is concerned with the quality of professional practice. Nevertheless, the accreditation process involves overseeing links between theory and practice, and hence is not 'divorced' from considering the theory underpinning practice. At the same time the policy emphasises the need to recognise the diversity of approaches to practice and teaching within homeopathy:

> Diversity within clear principles and Code of Ethics: The Society of Homeopaths supports the existence of a wide variety of approaches to the practice and teaching of homeopathy (ibid, p. 4).

According to the policy, what links the diversity of approaches to homeopathy in SoH accredited schools is that they are based on the classical principles established by the founder of homeopathy, Hahnemann, and adherence to SoH codes of practice.

> The diverse approaches to practice are linked by their derivation from the principles outlined by Hahnemann, commitment to clear and coherent philosophical principles, and adherence to the Code of Ethics and Practice of the Society (ibid, p. 4).

In stating the vision for education in homeopathy, the policy shows commitment to its holistic ethos:

> Accreditation and current recognition procedures also aim to support the development of the learning programme. In keeping with the ethos of homeopathy, this is holistic, integrating theory and practice as well as different aspects of the curriculum (p. 6).

In 2007 the Homeopathy Accreditation Board, part of the Society of Homeopathy Education Department (2007), published an accreditation handbook to guide the course accreditation process. In this document the commitment to the regulation of the profession and the accreditation of courses was reiterated:

> For the profession of homeopathy the education of practitioners is, very literally, the future and it is important that professional educators are accountable to both patients and students. Creating a credible accreditation process is a strong statement from any profession about its confidence to be scrutinised (Homeopathy Accreditation Board, 2007, p. 5).

Three years later the SoH introduced the document *Aiming for Excellence – Homeopathy and Higher Education*. The aim of this document was to guide SoH accredited homeopathy courses to be delivered to higher education standards at BSc level (Society of Homeopaths Education Department, 2009). Amongst the principles guiding the document was 'independence and creativity within an accepted code of ethics and practice' (ibid, p. 2). Maintaining higher education standards, the document indicated, requires two essential components which are at the heart of academic education - critical awareness and research mindfulness:

> In essence, students would be educated to a level that is broadly equivalent to a first degree (Higher Education Levels 5 and 6). The promotion of critical awareness and research mindedness would be crucial components (p. 2).

The document offered an approach which tried to balance these academic requirements with maintaining individual schools' significant degree of autonomy and maintaining the unique ethos of each of the homeopathy schools. This is clearly not an easy operation since it involves negotiating an agreed set of criteria in homeopathy education, while trying to ensure that these criteria are flexible enough to allow for each of the accredited schools to express its unique interpretation of knowledge of practice. Moreover, as the document indicated, managing this process is carried out by each school in relation to its own teaching. In a sense, in could be argued that this accreditation process is trying to avoid fully achieving standardisation of expert knowledge, which is the essence of formalising education. The following quote from the document demonstrates the effort to satisfy the diversity of homeopathic schools and the unique nature of each:

> We need to have a recognised and agreed set of criteria and a set of more *adaptable guidelines*, to give us both an accepted common framework and

> *the flexibility* to shape the course around the *uniqueness of the school* or college. [My emphases]
>
> These are not mutually exclusive but should operate symbiotically, even *intuitively*, to achieve your aims and philosophy [My emphasis].
>
> How each school or college responds to this criterion can be individual, as long as the evidence is clear and that teachers/lecturers are working with students to achieve this level of understanding and ability (p. 4).

The document highlighted three key elements of degree level education: curriculum content, teaching style and assessment. However, it also declared that 'how you [the school] implement and manage them is up to you' (p. 7). SoH educational documents avoided indicating clearly defined course content in the same way that the Standards for Education and Training for Acupuncture does in relation to acupuncture. However, the schools are required to ensure that their students are able to clearly demonstrate a defined set of practice-related skills. Such skills are defined by the National Occupational Standards in Homeopathy; they include the way that homeopathy's holistic premise is reflected in the documents. In the next section I move on to consider the link between SoH formal education and practice guidelines and homeopathy's holistic discourse.

7.4 The holistic discourse in educational/practice documents

While reviewing formal homeopathy documents the different ways in which educational policies and practice guidelines discuss holistic concepts becomes strikingly apparent. The National Occupational Standards (NOS) in Homeopathy produced by Skills for Health are set out to define the clinical skills that the trained homeopath should be able to demonstrate on graduation in order to practice. The Skills for Health (2009) NOS CNH15 refers to practitioners' ability to 'explore and evaluate with individuals factors relating to their health and well-being within the context of homeopathy (p. 1)'. In relation to practitioners' required knowledge of health and social well-being there is clear emphasis on matters of both wider self and wider world holism. Among the holistic aspects of practice that are highlighted by the document are the importance of considering the wider environments of patients; the need for a welcoming and attentive rapport in the medical encounter;

recognition of patients' individuality; and, the interrelations between body, mind and spirit:

> Health and social well being:
> How the psychological and emotional balance, as well as diet and lifestyle of the individual, can affect their health and well being
> How the context in which people live affects their health and well being...
>
> Consultation skills:
> The importance of a suitable environment and making clients feel welcome
> Effective ways of enabling individuals to talk through relevant aspects of their lives in a way which is sensitive to their needs and concerns (p. 2)
> Prepare and conduct the consultation in a way that allows full focus on the individual.

Note the very clear reference to the integration of wider world and wider self holism in the following practice-outcome, linking body, mind and spirit interrelations with the broader environment and social concerns:

> The scope and significance of the physical, mental, emotional, social, spiritual and environmental factors which should be explored with individuals, including:
>
> i) onset, duration and intensity/severity of symptoms
> ii) current physical, mental/emotional/spiritual and general states and modalities of a general or particular nature...
>
> v) significant life events and reactions to them
> vi) lifestyle, work and home situation including any stressors
> vii) reaction to environmental and social factors
>
> (Skills for Health, 2009, CNH 15 p. 3)

Not only do these practice guidelines demonstrate consideration for a range of wider self and wider world holism factors, the document also takes into account some of the concerns that were raised in the literature in relation to holism. For example it refers to the concern with the increased interpretive authority in homeopathy which I discussed in Chapter Five, pointing at the need of practitioners to be aware of the limits of their professional role:

> Performance Outcomes: You must be able to do the following:
>
> The limits and boundaries of the practitioner's role and when there may be a need to advise the individual to consult other health care practitioners
> The importance of not imposing one's own beliefs, values and attitudes on individuals, of enabling them to express themselves in their own way and of recognising the value of their own beliefs, attitudes and experiences (ibid).

Arguably, advocating for higher education standards in homeopathy education while maintaining a significant degree of autonomy by the homeopathic schools may resolve some of the concerns over losing the unique ethos and holistic premise of homeopathy. The question is whether maintaining this kind of status quo between regulation/standardisation and autonomy of practice allows for a convincing enough professional project. In the next section I will discuss NMQ homeopathy practitioners and schools' divided views over HE involvement and the formalisation of homeopathy education.

7.5 Homeopaths' divided views over university validation and formalising education

In Chapter Three I described the opposition that HE CAM courses in general, and homeopathy in particular, face from what can be described as the 'anti-homeopathy camp'. While facing this external opposition to the teaching of homeopathy within universities, also from within homeopathy there is no wall-to-wall support of this HE involvement in homeopathy education. On one hand, some, like Penny, the homeopathy college principal who is also an active member of the SoH, argue that despite the diversity of approaches in homeopathy, there is a need to establish clear boundaries for the knowledge that homeopaths obtain. This diversity contributes to a fluid definition of homeopathy practice. Penny argues that this fluidity confuses the public and makes it difficult to provide homeopathy with a clear professional outlook, hence there is a need for some sort of standardisation of professional knowledge:

> Ultimately I think the axe has to fall and this is where it all becomes homogenous with what the public think, with what the government wants, with what we want as practitioners. The axe has to fall between people who

> are offering homeopathy as in 'classical homeopathy', and I mean broad church 'classical', I don't mean just what Hahnemann or maybe Kent say. I just mean 'honesty', 'goodness', 'one remedy', 'one totality', 'suck it and see' [the remedy]. Let's try and find the similimum.
>
> Nothing to do with dowsing or reiki, radionics, crystals, or colour therapy, or [homeopathic] remedies that have not been proven. Let's draw a line and say 'this is who we are and this is the body that represents us'. Now, I am not saying that those practitioners can't also practice all those other things, but if the public is looking for a homeopath – then they are looking for a homeopath!

At the same time that Penny strongly supports the standardisation of homeopathic knowledge and the involvement of HEIs in that process, she is aware of the concern with the formal nature of HE, and its potential impact on the informal nature of some homeopathy training:

> Penny: As attractive as degrees are, they are not what everyone wants to do.
>
> A: In what sense?
>
> Penny: [for example] we had three students who came from an independent course that then became degree accredited with Thames Valley [University] and they felt the whole ethos of the course was changing so dramatically that it wasn't the kind of homeopathy they wanted to be part of.

Louise, who has been practising successfully for 10 years after graduating from a non-BSc awarding course, would be happy if the profession would get 'the recognition it deserves' as a 'legitimate academic discipline', but she is not 'that bothered' about homeopathy being taught at BSc level. She suggests that some academic courses are compromising the depth of homeopathic knowledge because of the demand to align them with academic standards. She uses quite harsh words in relation to what she perceives as the dilution of homeopathic knowledge during the process of HEI validation of homeopathy courses:

> The students I've come across so far who study homeopathy university courses tend to be still very classically trained [as in classical homeopathy] and I kind of approve of what they're learning. But there are some courses I've heard about, although I don't know where, that seem to be kind of 'lightweight'. It seems to be a bit sort of ... trying to almost appease the system.

> Actually you don't need to worry about that in my opinion because homeopathy stands on its own. I wouldn't be that bothered about degree status, frankly. You know, it would be lovely if it got the recognition it deserved but I don't think we should persecute ourselves and, and dilute our amazing profession just to try and placate the powers that be.

One of the leading homeopathy schools was established by a well known homeopath, and has a group of renowned homeopathic lecturers teaching on the school's courses. On its website the school describes how it rejected approaches from several universities to validate the school. This, it is argues on the school website, was in order to maintain the school's monopoly over the way knowledge is taught, and avoid having to comply with what the school refers to as 'institutional agendas', and to the loss of control over the creative nature of homeopathy. In the following quote from the school website HE validation of homeopathy courses is rejected:

> We have been approached by universities in the past, but we have decided to remain independent. A few colleges in the UK have turned to a university campus for degree status. *However you do not need a degree to practice homeopathy*.
>
> Our independence ensures *we maintain creative control of our course*, *keeping us free* to develop and change so you receive the best education and are kept up-to-date with the latest homeopathic developments.
>
> Plus for our students, *the informal, natural and healing atmosphere of the course and School*, with its small classes and home study, *is a blessing that cannot be replicated in the institutional setting* of a campus course.
>
> This also allows us, *unhindered by institutional agendas***,** to continue in providing the forward-looking ethos and flexibility for which we are world renowned [my emphases].

Another homeopathic school conveys similar (albeit more subtle) criticism of HE accreditation of homeopathy courses. On its prospectus, the school's creative educational approach is presented in contrast to more formal education of HEIs which the school describes as 'fulfilling criteria' and merely 'acquiring vast amounts of information':

> The focus [of the course] is on an organic and creative system, firmly structured and boundaried by the principles of Homoeopathic philosophy,

> rather than the type of modular system more appropriate to secondary education in schools.
>
> Through this deepening process over the four years, our students develop a greater understanding of the art of Homoeopathy and its medicines, rather than simply acquiring vast amounts of information.
>
> In other words, we're interested in the process of education – its fluid nature, unexpectedness and diversity rather than fulfilling criteria.

This unenthusiastic approach to HEI validation of homeopathy courses is not shared by all schools. The fact is that several homeopathy schools were validated by universities in the past, and one still is. Moreover, also today, after the number of university validated homeopathy courses has dropped dramatically, there is still support for HEIs' involvement in homeopathy education by some of the schools. For example one school proudly describes in its prospectus how some of its graduates were involved in the development of university validated homeopathy courses around the country:

> Our graduates have variously been the Chair and Vice Chair of the Society of Homeopaths, and responsible for its Journal, Ethical Practice and Research functions. They have set up or run homeopathy courses at [name] University, the [name] University and [name] University.

A hint of the complex relationships and infighting within homeopathy in relation to the degree of formalisation of homeopathy courses is demonstrated in a newsletter article by the chair of the Alliance of Registered Homeopaths (ARH). The ARH is a competing professional body with 580 members on its online register. In the article, she argued against the SoH's efforts to pursue statutory regulation. In a rather dramatic tone she suggested that statutory regulation of homeopathy will result in 'surrendering our autonomy to the state' and 'surrendering the soul of homeopathy to a system only intended to control function':

> *Surrendering our autonomy to* the state has potentially serious ramifications for the homeopathy profession, both here in the UK, and in the rest of the world, where our actions are often regarded as setting the standards to which other countries should aspire.

> *This places a tremendous responsibility on us* to make the right decisions for the right reasons, and any choices we make regarding the regulation of homeopathy must be informed choices. As homeopaths, *we are the custodians* of a complex, finely balanced discipline, and we have a duty of care to ensure we *preserve the integrity of homeopathy*, complete with all its nuances, for the ongoing benefit of our patients.
>
> This leads to an absolutely crucial question; what benefit can SR [Statutory Regulation] bring to homeopathy? ...True, statutory regulation does secure the title 'homeopath'. However, the price for that protection means *surrendering the soul of homeopathy to a system only intended to control function*. Homeopathy and homeopaths deserve better [my emphases].

In contrast to those who oppose HEIs validation of homeopathy courses, several of my interviewees were concerned with the kind of 'separatist' attitude within homeopathy that is demonstrated by the above quotes, and its impact on their professional project. For example, Mick, who plays an active role in the SoH, points out:

> I think we've made a few errors in the past and we're perceived as being a bit 'holier than thou', 'we can't do that', 'we're too good for that'. There is a sort of … I think a bit of arrogance which probably was not meant, to be quite honest.

Penny argues that formalising homeopathy education is an opportunity for the profession to grow out of 'the elitist criticism' that is often mentioned in relation to homeopathy, and which portraits homeopathy as a 'snobbish' profession that is linked with the social elite:

> I don't have any fear of higher education and I want my graduates to have fearlessness about education, too. It is only going to help us. You know, we've been criticised in the past for being 'elitist' or 'cultish', and that our research is not done properly and we should take that on the chin! And we should say 'yeah OK, maybe there is some truth in this fuss and we have to grow.
>
> It doesn't mean that we can't be intuitive prescribers; it doesn't mean to say that we are not going to keep learning about the latest trend in our homeopathy as we like the feel of it.

Sally is a homeopath and a nurse who is in charge of the provision of CAM in an NHS hospital. She used to be a lecturer in one of the homeopathy colleges. She is concerned with the way that some purist (i.e. strictly classical in their approach to practice) homeopathic schools oppose the formalisation of courses and the university validation of homeopathy courses in the name of protecting the 'purity of homeopathic knowledge'. She argues that by maintaining an 'exclusive', 'separatist' approach that rejects input from HEIs and from other disciplines, the 'separatists' are being intolerant of other approaches and other kind of healthcare practitioners:

> There is too much sort of separation with it [homeopathy training]. It [names one of the homeopathy colleges in the UK where she was trained] was very 'purist', which I found very difficult sometimes. Because I can't work classically here [at the hospital], 'cause, again, a classical homeopath wouldn't take on the cases I take on. A classical homeopath would say 'they should go and get off the chemo' and 'they shouldn't be having surgery'. We are living in the 21st century!
>
> And as long as you have those purist opinions you're not going to integrate. And to integrate it's not 'selling yourself to the devil', although it did feel like that at first. It's actually just integrating … I don't know. I find doctors and homeopaths and anybody you know, probably some of the naturopaths and stuff, they have a blistering intolerance of other people, there's only one way of doing it and it's their way, and that's the problem.

So far in I have described several challenges to the formalisation of homeopathy education. The introduction of BSc (Hons) homeopathy courses from the mid-1990s appeared to have signalled another acceleration of formalising homeopathy training in the UK. Moreover, as we can see, SoH continued developing impressive guidelines and documentation to ensure that homeopathy courses are standardised and are delivered at HE level. However, despite these developments, it seems that the 'old' barriers that were identified more than a decade earlier, and the reluctant nature of parts of the homeopathy profession in relation to the formalisation of education, have yet to be overcome. In the following section I will discuss data from SoH accredited homeopathic schools, to consider the relationship between formalising education and the holistic discourse in homeopathy. As I showed in Chapter Five, the way homeopaths negotiate the

holistic discourse is insightful in relation to the strategies enacted by homeopaths in negotiating the tensions that are part of formalising education.

7.6 The holistic discourse in SoH accredited homeopathy courses

The past few years have not been easy for homeopathy education. Out of the 15 homeopathy courses that were listed in 2011 on the SoH recognised courses list, three BSc (Hons) Homeopathy courses are now closed. When reviewing homeopathy courses' information, several observations can be made. There seems to be a striking gap between the formal language used in SoH educational and practice guidelines and the rather informal and often esoteric language used by some of the schools on their websites and in course syllabi. Such fluid, non-standardised presentation is arguably in contrast to the nature of a professional project and the desire to instil homeopathy training with a credible outlook. Moreover, although the NOS for homeopathy practice places an expectation that homeopaths are equipped with significant knowledge of scientific research and human biology; this is not always followed up by the homeopathy schools in the same way.

As outlined in Chapter Five, there is a significant holistic discussion taking place in the homeopathic schools. At the same time, the nature of the holistic discourse in the different schools is diverse, and seems to be tied to the unique perspective and unique ethos of each school. Some schools represent themselves and their courses using 'standard professional' information while avoiding discussing what esoteric theoretical concepts. Perhaps by reducing the focus on unscientific esoteric knowledge, these schools wish to increase the formal, mainstream outlook of homeopathy. In contrast, other schools maintain in their online representation and course information a focus on the holistic and esoteric nature of practice, which is part of homeopathy's appeal since its re-emergence as part of the medical counterculture. In between, it seems that several courses are trying to strike a balance between a professional, formal outlook, while maintaining a holistic representation of practice. Let me provide several examples from the data of this diversity in the representation of expert knowledge. At the most 'non

biomedical end' of the rhetoric used by SoH courses is the use in esoteric language such as that of the following school:

> The ethos of the School is one of living in harmony with nature. We believe that the universe will be more generous in its gifts of knowledge and learning if we are more in tune with its needs. Gaia gives us the remedies by which we work, it is our belief that we give her respect in return through nurturing the ground that we walk upon.
>
> The [school] campus is a venue like no other. Our aim is to not just provide a room, but a whole, holistic environment. We feel that everything about a learning space is vital for it to be truly nurturing.

The aforementioned language on the school's website emphasises the holistic nature of homeopathy in contrast to the 'reductionist nature of biomedicine'. This kind of discourse conflicts with SoH professional efforts to narrow the homeopathy/biomedicine gap. Note how the text below from the school's website makes a range of holistic claims which contrast with biomedicine's 'reductionist nature':

> Homeopathy is very different from conventional medicine in virtually every regard. The homeopathic view of the nature of illness, the interpretation of symptoms, the nature of the medicines are all areas where Homeopathy is completely at odds with the views of conventional medicine.
>
> The conventional view of illness, which we are all very accustomed to, is based around a very mechanistic understanding of the human body....
>
> Homeopaths feel that since all the parts of the body are intricately connected, you must treat the integrated whole, not the isolated symptom....
>
> Conventional medicine views symptoms as something to be removed. They are seen in isolation from the rest of the body, and medicines are taken or applied to make the symptom disappear....
>
> Homeopathy takes a holistic view of health. It is the whole body that is ill, and therefore symptoms cannot be considered in isolation. The body tries its best to cope with disturbances that affect it, but there are times when it is not able to fully recover.

While this kind of esoteric language is not common, the description of homeopathy as inherently holistic appears quite often. For example, the following text is taken from another school:

> There is now a move towards less invasive methods of healing, and an increasing awareness of profounder holistic approaches like homoeopathy...
>
> Philosophy Syllabus: Individuality. The recognition of our differences and the need to treat individually; One size does not fit all. We treat the person, not just the disease; Healing Holistically. Spirit-mind-emotions-body-everything is connected ...; there is really only one disease – an imbalance of energy.

Another school also describes homeopathy while listing its holistic attributes:

> Homeopathy seeks to harness this self healing tendency by stimulating and supporting the 'defence mechanism' rather than taking over from it.
>
> Patients are treated as unique individuals. Rather than labelling you as suffering from 'such and such' a disease, a Homeopath will listen to your story and respond in a relaxed and non-judgmental way.
>
> Homeopathic remedies work without side effects, in harmony with the body's own healing powers.
>
> Homeopaths take all aspects of a person into account when making a diagnosis, therefore physical symptoms, emotions, sleep patterns and even family dynamics are considered before a prescription is made.

Such reference to holistic notions in homeopathy is also found in the information provided by a couple of other SoH accredited courses. Nevertheless, in these schools the holistic representation of homeopathy is accompanied by what can be described as a more formal and 'professional' kind of language. By that the schools are trying to balance 'professionalism' with the indeterminate nature of expert knowledge. In fact, at the other end of the spectrum, two of the homeopathic schools chose to altogether avoid discussing homeopathic

philosophy or its holistic grounding, using strictly technical, formal language. One of these schools chose to focus on the academic nature of the course:

> Why study with us? You'll be awarded a BSc (Hons) in Homeopathy (validated by [name] University) and/or the LCHE – both recognised professional homeopathy qualifications; the highest quality teaching in both classical and practical homeopathy. An academic curriculum designed to give you the appropriate knowledge for each stage of the course.

Another homeopathic school avoids presenting philosophical principles or homeopathy's holistic premise. Moreover, the following text seems to contain a subtle critique of the lack of clarity and 'over theorisation' by some of the other schools. Note the emphasis in the following text on a 'no nonsense' approach and on practicality and clarity in homeopathy:

> Our philosophy is based on the traditional principles of homeopathy, while at the same time, offering a practical and up to date approach, meeting the needs of people today. We pride ourselves on a 'no nonsense' training that emphasises the importance of clear and accessible communication.

It seems as if the gap between the very well-articulated and laid-out formal educational/practice guidelines produced by the SoH, and the need to satisfy each school's unique ethos is creating a rather 'nonstandard' educational outlook. Possibly as a result of the fear of losing the holistic premise of homeopathy, different schools adopt significantly varied approaches in relation to the teaching of technical, biomedical knowledge.

Some of the schools have a core research methods unit, while others do not mention this subject in their course syllabi. This seems to point to a certain gap between SoH educational documents which I presented earlier in this chapter which call for the development of practitioners' 'research mindfulness and critical awareness' (for example the document 'Aiming for Excellence'), and the way such guidelines were interpreted by some of the schools. Moreover, the NOS for

homeopathy specify that homeopaths should be able to understand ‘different research methodologies and findings, and their relevance to practice’ (Skills for Health, 2009, p. 2).

While some courses deliver extensive teaching of anatomy and biology and consider this knowledge as part of the professional arsenal of homeopathy practice, other schools do not place the same emphasis on it. Two of the schools teach this subject extensively over three complete modules that are taught over three years. In addition, some other schools clearly recognise the inclusion of biomedical sciences as an integral part of contemporary homeopathy knowledge. For example one school, in its mission statement, emphasises the importance of increasing students’ knowledge of human biology alongside the description of the holistic attributes of homeopathic education:

- An evolving understanding of the human being, from the exterior to the interior (so that the deepest pathology is studied later) underpinned by a well constructed understanding of anatomy, physiology and pathology. With a case-taking perspective throughout, students can develop in safe clinical practice, where they can effectively integrate all their knowledge.
- An education as holistic and deeply grounded as homoeopathy itself, with students growing in self knowledge, wisdom and spiritual awareness, into well rounded, confident, and skilled practitioners.

In contrast, some of the schools appear less enthusiastic about the teaching of the subject. One school delegates the teaching of anatomy and physiology to a distance-learning course that the students are required to take outside the core school teaching. Another school incorporates self-study of anatomy and physiology that is complemented with formal lectures. Note in the following quote from the course’s syllabus, how, unlike the aforementioned school, here the subject is considered as ‘a different kind of medicine’ rather than integral to homeopathy:

> Medical Sciences. Why is it necessary? Although homeopaths practice a different form of medicine, we still need to have an understanding of conventional medicine.

Strikingly, in relation to matters of wider world holism, I found no direct reference in schools' information to the broad environment of patients, aside from the patient's immediate social environment, i.e. family, friends or work. There was no mention either in online information provided by the schools or in the course's syllabi of the impact of life circumstances, be they be cultural, sociological, or political-economic factors, which affect people's lives. This lack of consideration appears to reinforce the criticism that CAM's holistic discourse is mainly constrained to matters of wider self holism. Increasing wider world awareness requires the development of a sense of critical awareness and research mindedness as indicated in the document *Aiming for Excellence* and by the practice guidelines and it seems that this recommendation is not adopted by all schools.

Scott (1998), in her discussion of homeopathy as a feminist form of medicine, points out that the individualistic ('wider self') emphasis of homeopathy can be partially explained by the fact that NMQ homeopaths practice mainly in the private health sector. Since they offer their treatment as a commodity, it is not in their economic advantage to locate the treatments in factors outside the patient's immediate control (ibid, p. 200). This might be linked with the lack of 'wider world discussions' in my participants' narratives, the presentation of 'symptoms and conditions homeopathy can treat' on practitioners' websites, or the lack of direct references in schools' information to the broad environment and 'public health' concerns. However, Scott argues, homeopathy may be individualistic *in practice,* but social issues are central to its *theory*. According to homeopathic theory, illness is caused as a result of the vital force's response to environmental and social stresses. Scott discusses the work of the prominent Indian homeopath Rajan Sankaran, who argues that each homeopathic remedy represents a bodily/emotional 'posture', which is the individual's adapted response to certain social or environmental situations. Constitutional homeopathic treatment, Sankaran argues, involves the matching of the homeopathic remedy with the patient's 'posture', helping the patient to move more freely out of it. Overall, Scott argues, the integration of social and environmental factors is intrinsic to homeopathy theory. Nevertheless, as mentioned previously, and as evident in my practitioners' narratives and in the varied information presented by the different

homeopathic schools, such engagement of homeopathic theory in relation to the social world and the environment is likely be significantly different from practitioner to practitioner. For example, not all schools and not all practitioners adopt Sankaran's approach to homeopathy with its profound social/environmental engagement. As demonstrated in Chapter Five, The homeopaths I interviewed were not attuned to wider world holistic concerns and this corresponds with the apparent lack of such engagement in schools' information. In contrast, the participants in Scott's study were selected also on the base of being actively engaged in health politics, and this might be linked with the kind of homeopathic theory and practice that they adopted.

7.7 'Keen' versus 'reluctant', 'pragmatic' versus 'idealistic': discussion of Chapters Six and Seven

As I have argued in Chapter Five, the holistic discourse of the therapies is a useful point of reference to examine the strategies of practitioners and the way that they negotiate the environment in which they operate, as well as the tensions that are part of formalising their education. In Chapters Six and Seven I considered the relationship between the process of formalising education of NMQ acupuncturists and homeopaths and their holistic discourse. For over three decades, both practitioner groups have been engaged in the formalisation of their educational structures and standardisation of their courses. In order to increase the external legitimacy of their practice, as well as differentiate themselves from 'unqualified', 'unsafe' practitioners, both BAcC and SoH developed detailed educational and practice guidelines, course accreditation mechanism, and a register of qualified practitioners. These guidelines include infusion of biomedical science and biomedical research methods into the curriculum, and an increased emphasis on RCTs to demonstrate the safety and efficacy of their practices. Historically, the process of formalising education involved a number of significant challenges, including disagreements amongst practitioners and schools regarding the degree of alignment with biomedicine, the fear of losing their autonomy over the form and the content of the taught knowledge, and centrally, the fear of losing the holistic and individualistic nature of practice (Cant & Sharma, 1995; Clarke et

al., 2004; Kelner et al., 2006; Saks, 2003b). This lack of cohesion and inner-division particularly identified homeopaths (Cant & Sharma, 1995; Kelner et al., 2006), where strong-minded school leaders often maintained a position of 'guarding the purity of homeopathy'.

In recent years there were significant changes in relation to CAM, in consumers' behaviour, power, and desire for more individualised and participative engagement, as well in the attitudes of conventional medicine and of allied to medicine professions (Cant, 2009). At the same time, Cant argues, 'whilst the significance of these changes should not be underestimated, they do, however, mask notable continuities' (Cant, 2009, p.193). CAM is still mainly practiced in the private sector (Hunt et al., 2010), the increased integration of CAM in the NHS is largely provided and managed by conventional doctors (Saks, 2005a) and biomedicine maintains its jurisdictional boundaries and the superiority of the biomedical model (Cant, 2009).

So what, then, has changed in the way acupuncture and homeopathy training is organised? And how did it affect the holistic nature of the therapies? First, a significant change since the mid-1990s is HE involvement in CAM education (Isbell, 2004), a development which has arguably not received sufficient attention in the literature. The question is how HE, as a powerful mainstream institution, affected this process. Second, from the perspective of 'professionalism', as noted by Clarke et al. (2004), formalising education and standardising practice should be seen in the context of practitioners' 'expert' position. The continuous process of acupuncture and homeopathy courses' standardisation has served to separate between 'dangerous' and 'competent' acupuncturists and homeopaths (Cant, 2009), to ensure the trust of the public, the state and the medical profession. In acupuncture, in 2010, all but one BAcC courses were validated by universities. In homeopathy, while the number of SoH university validated courses dropped, there was still an aspiration and commitment by the SoH to maintain 'HE standards' (Society of Homeopaths Education Department, 2009). The entrance of HEIs, and/or of aspiring for HE standards, accentuated a certain paradox in the formalisation of acupuncture and homeopathy education. While it accelerated the process of 'formalisation', to a certain degree, HE involvement increased the

tensions and difficulties that existed previously, including the tension between formal and informal teaching approaches; the debate over the degree of alignment with biomedicine and with biomedical research; reducing the I/T (Indeterminacy/Technicality) ratio of expert knowledge by increasing its standardisation - and with it losing the degree of practitioners' autonomy over their own practice and increasing transparency of expert knowledge; and the fear of losing the holistic ethos of the therapies in the process of alignment to biomedicine.

In the case of homeopathy, as opposed to acupuncture, the 'reluctant nature' concerning standardising education and training clearly remains. The divisive nature of NMQ homeopaths and the inner-divisions remain a significant barrier to the professionalisation of homeopathy. Over a decade ago Saks (1999) pointed out that SoH is working to achieve greater internal cohesion in their effort to professionalise homeopathy through formalising education and establishing a register and a code of ethics, but it 'has not yet reached the level of ideological unification of the acupuncturists' (Saks, 1999, p.132). Indeed, while developing increasingly detailed guidelines for education and practice, in trying to ensure that schools maintain their autonomy and unique approach to practice, SoH efforts to standardise education is compromised. The degree to which courses syllabi are standardised is highly flexible and varies greatly between schools. The expression of both esoteric and biomedical knowledge differs from school to school and there are significant gaps between practice and the educational guidelines that are published by SoH, and the interpretation of it by the individual schools. Moreover, while SoH declares commitment to HE standards, some of the schools reject the formal nature of university education. It seems that the 'reluctant' nature of NMQ remains as it was: moving forward in formalising education, but without addressing the obstacles to this process. The result, as one homeopathic school principal argued in frustration, is SoH inability to provide clear definition and clear borders to homeopathy practice.

In acupuncture, while schools still maintain a degree of autonomy over the style of practice and the interpretation of Chinese medicine philosophy, there is far greater

cohesion in the process of formalising education. The fact that nearly all BAcC accredited courses are taught at undergraduate level requires a significant degree of standardisation as part of adhering to HE validation and with it HE standards and guidelines. The standardising of the different courses' syllabi is more consistent than in the case of homeopathy, and schools appear to follow BAcC guidelines more closely. The infusion of medical sciences and biomedical research is followed by all schools and so is the definition of professional competencies as evident by all courses' syllabi. This infusion is portrayed on schools' website and courses' information as welcomed and as enhancing professional knowledge rather than as something that is forced upon them. Still, acupuncture courses are not free of debates over the nature of acupuncture practice or the tensions that are part of formalising education. There are clear, often unresolved, difficulties in addressing the tension between the holistic ethos of acupuncture and the infusion of biomedical sciences. It is clear from practitioners' narratives, from my participant observation, as well as from courses' syllabi, that the emphasis on RCTs in acupuncture and the inclusion of significant teaching of biomedical sciences are complex to manage. Nevertheless, all three school principals I interviewed expressed satisfaction with the way that the university-validation process was negotiated, and the degree of 'holistic expression' that they were able to maintain on their courses.

Acupuncturists appear to take a more practical approach to formalising education, and, while recognising the complexities that are part of the process, they perceive the benefits to be greater than the costs. Clearly, they have one significant advantage that, as highlighted by Cant and Sharma (1996b), is important part of engaging with professionalisation strategies: they are unified in their efforts and they, to a large extent, agree about their professional identity. In fact, BAcC school principals in my research study periodically meet together to consider educational strategies and matters at the heart of acupuncture education. It seems that, as a result of being more unified, they are able to ensure greater codification and standardisation of education, agree on the degree of infusion of biomedical sciences and RCTs, and establish more standardised training programs. Arguably, to a degree, by their decisive and committed efforts they were able to increase the status of NMQ acupuncture and increase their external

legitimacy, although somewhat ironically, by achieving standards of safe practice they were denied statutory regulation (Department of Health, 2011).

At the same time, the adoption of acupuncture by medical and allied to medical practitioners, while curtailing and often rejecting the traditional roots in favour of biomedical explanatory models, can be seen as highly political and as denying the holistic nature of traditional acupunctured (Jackson & Scambler, 2007). There is a large number of scientific peer reviewed journals[41] and RCTs on acupuncture[42], and while, it can be argued, such studies biomedically 'appropriate' and even transform acupuncture, they provide acupuncture with a certain external legitimacy. Traditional acupuncturists, in a study by Jackson and Scambler (2007), showed a great deal of scepticism and ambivalence towards EBM and RCTs and their suitability to evaluate their practice. They view the need to research acupuncture using RCTs as 'playing the game by biomedicine's rules' (ibid, p.421). Nevertheless, as I showed in Chapter Five, many practitioners make use of RCTs on their websites in order to increase the legitimacy of their practice. Moreover, in 1994 the BAcC established the Acupuncture Research Resource Centre (ARRC), which gathers and publish information on RCTs on acupuncture.

It is hard to establish whether the fact that, overall, HEIs adopted acupuncture more favourably than homeopathy, as evident by the number of BSc courses that are currently recruiting at British Universities, is due to a more committed effort by BAcC or is the result of this external legitimacy – even though such legitimacy is provided more to medical rather than traditional acupuncture. At the same time it is unfortunate that homeopathy has lost several university courses that contributed to the development of critical thinking and what Vickers describes as 'healthy scepticism':

> The development of training institutions in the private sector has also had the effect of distancing complementary therapy education from the

[41] For example: *Acupuncture in Medicine* (by *BMJ*), *International Journal of Clinical Acupuncture*, *Journal of Acupuncture and Meridians Study*, *The Journal of Chinese Medicine*

[42] A Pubmed Medline online search on 6 August, 2012 of clinical trials from the past 10 years yielded 143 results on homeopathy compared with 2240 results on acupuncture.

> university setting. The effect of this has been profound because the university is the cradle of critical thinking, of analysis, of healthy scepticism towards accepted wisdom. It is where new ideas are tested and developed, where, arguably, the most significant scientific, social, philosophical and humanities research is undertaken.... Complementary medicine has been cut off from a fertile source of creative and critical thinking and lost access to human, technical and financial resources that are vital for good quality research (Vickers, 1998, p. 4).

HEIs validation, the degree of infusion of biomedical science and the increased emphasis of RCTs require professional bodies, schools and practitioners to re-visit their holistic discourse. In the case of homeopathy, it seems that for some of the schools there is an *attachment* of the degree of their 'holistic expression' with the degree of mistrust in standardising and formalising their education. Unsurprisingly, it seems that schools that use more esoteric language and holistic expressions, and that maintain less alignment with biomedicine, are also less enthusiastic about HE involvement in homeopathy education and are less engaged with the process of standardising homeopathic knowledge. Such schools seem to adopt an idealistic stance in relation to the nature of homeopathic knowledge, as 'guardians of the purity of homeopathy'. In contrast, homeopathic schools which are more willing to temper their knowledge claims and align their courses with biomedical knowledge, appear more enthusiastic about adopting HE standards and the degree of formality that is attached to it.

In the case of acupuncture, it seems that schools developed a certain *detachment* between their holistic and esoteric expression, and the process of formalising and standardising their courses (and with it the alignment with biomedicine). As a result, schools are able to express their unique holistic approach, while at the same time there is a parallel emphasis on RCTs, biomedical research and biomedical knowledge. This can be seen as a strategy, similar to the one adopted by individual practitioners (of both acupuncture and homeopathy), when negotiating the tension between the conformity to formalisation of education and maintaining the holistic principles of practice. While several traditional acupuncture schools present highly 'unscientific', esoteric concepts on their websites, all BAcC schools, with no exception, include significant teaching of medical sciences, as well as highlight the importance of biomedical research. For

the acupuncture schools, and those homeopathy schools who support HEIs standards to homeopathy education, HE is seen as an opportunity to increase their external legitimacy by collaborating with a major mainstream institution and by increasing the allegiance with other academic and professional disciplines. This collaboration is used to mainstream practice and signal safe, responsible, knowledgeable practice, demarcating NMQ acupuncturists and homeopaths from other untrained ones even further.

Moreover, despite the complexities and tensions that are part of formalising education, the increased involvement of HEIs brings several important contributions to the professional development of acupuncturists and homeopaths, which are reflected in their holistic discourse. I argue that HE involvement in formalising the therapies' education can increase practitioners' reflectivity in relation to their own practice, and, in particular, increase the scope of the holistic discourse from the focus on wider self holism to wider world awareness. For example, my participant observation demonstrated the difficulties students face in having to negotiate esoteric, traditional acupuncture knowledge with biomedical knowledge, but such challenge requires both staff and students to engage in a process of reflection and consideration of these tensions. At the same time, in courses that are taught within universities, the interaction with a number of academic disciplines and other health professions inside faculties and schools may bring with it increased awareness to matters such as the broad environment and its impact on people's health, and to the importance of inter-disciplinary healthcare. There are certainly examples of the development of wider world awareness as part of the curriculum, mainly in the university based courses. Possibly, this can develop to a sort of 'wider world holistic alignment'.

Chapter 8:

Conclusions

In this final chapter I will discuss the main findings of the research presented here. The conceptual threads guiding the research study are considered in relation to the empirical data in the context of the research questions. While reflecting back on the study as a whole, I will highlight methodological issues, my empirical and conceptual contribution to existing research, the limitations of the study, and the implications of my findings to acupuncture and homeopathy education and practice. Finally I will identify areas in the thesis which point to potential future research. In examining the holistic discourse of NMQ acupuncturists and homeopaths, I considered practitioners' strategies and the way that they respond to, and negotiate, the environment in which they operate, as it is reflected in this discourse. The holistic discourse reflects the way that the two practitioner-groups navigate their efforts to professionalise, increase their societal status and their external legitimacy, while trying to maintain their holistic ethos, as well as maintain their appeal to their client base. I began by examining acupuncturists' and homeopaths' holistic discourse, the meanings which the two practitioner-groups attach to holism, and practitioners' reflectivity in relation to this discourse. I then moved on to explore the challenges that the two therapies face in their efforts to formalise their educational structures while guarding the holistic premise of their practice, the strategies that they enact in negotiating holism and formalising education, and the impact of formalising education, including the involvement of HEIs, on the holistic discourse itself.

While the holistic discourse is central to acupuncture and homeopathy theory and practice, my main point of departure, as described in my findings, is that this is a *dynamic discourse* which changes its shape, and the expression of which can be *narrowed* or *expanded* in relation to circumstances and audiences, and in relation to the social and political environment in which practitioners operate. At times practitioners are trying to increase their external legitimacy by downplaying or narrowing the holistic scope of their practice, while at other times they choose to

demarcate their knowledge from biomedicine by emphasising their holism and their holistic engagement. Throughout my thesis I have considered the work of a number of scholars, and I used this body of knowledge to explore my research questions. In conceptualising my work I built, in particular, on the work of Scott (1999) in relation to the holistic discourse in CAM, Witz's (1990) discussion of closure strategies, and Jamous and Peloille's (1970) discussion of the indeterminacy/technicality ratio in professional knowledge. In this thesis I re-visited and examined recent development in the formalisation of acupuncture and homeopathy education, by focusing on the therapies' holistic discourse as central to the therapies' philosophies and practices, and as a centre of tension between formalising education and maintaining the unique nature of expert knowledge. In particular I drew on the work of Cant (2009), Cant and Sharma (1995, 1996b), Cant et al. (2011), Sharma (1996), Saks (1999, 2003b), Clarke et al. (2004), Gale (2009), Welsh et al. (2004), Kelner et al. (2004, 2006), Boon et al. (2004), and Jackson and Scambler (2007). Before discussing my conclusions, I would like to reflect on the generalised inference of my findings.

As I discussed in the methodology chapter, it is often argued that the role of qualitative research is not to generalise in the same way that quantitative research aspires to, but rather to provide a rich, contextualized understanding of certain human experiences, by intensively studying particular cases (Polit & Beck, 2010). At the same time, as argued by Polit and Beck (ibid), in-depth qualitative research may reveal concepts and theories that are not unique to one particular setting, this is because of the rich and detailed nature of the findings, which makes them especially insightful in relation to other settings. *Analytical generalisation* is the striving to generalise from the particulars to broader constructs or theory (Firestone, 1993), and *transferability* involves using findings from one inquiry to a different group of people or setting (Polit & Beck, 2010).

In order to enhance the generalised inferences of my findings, I used a number of methodological strategies: a) in selecting my sample for interviews, I used purposive sampling to illuminate critical aspects relating to my research question, b) I analysed my data to the point of *saturation* to enhance the likelihood of

analytical generalisation, c) I considered my data in relation to earlier research which was conducted with quite similar observed groups in both the UK as well as in other settings. This was essential in considering relationships, concepts and patterns, and strengthen the meaning of my findings, d) I was consciously engaged in thinking conceptually, as analytical generalisation involves abstraction of general concepts from particular observations (Polit & Beck, 2010), and in analysing the findings, I placed the accumulated findings in relation to conceptual threads, and e), through the in-depth qualitative nature and mixed-method approach of my research study, I developed a significant degree of engagement with the data. Moreover, through practitioners' narratives as well as through my observations, I have tried to provide a detailed description of my research setting and of my findings, to move towards a 'thicker description' that allows a greater degree of transferability.

8.1 Main findings: pragmatic holism

I will now move on to highlight the main findings of my research study in relation to the first two research questions:

- What are the meanings attached to 'holism' by NMQ acupuncturists and homeopaths in England?
- To what extent are NMQ acupuncturists and homeopaths in England reflective in relation to their holistic discourse?

Sociological literature conceptualises holism as a major part of the appeal of CAM since its re-emergence alongside the medical counterculture in the mid-1960s. The term was used to highlight the therapies' anti-reductionist, anti-dualistic and anti-oppressive nature, and the way that CAM differs from biomedicine. It is clear, when looking at the data gathered in this research, that several decades later, despite efforts of practitioners to increase their professional status through professionalisation, holism is still a central concept in both therapies' discourse. At the same time, the fact that holism is not clearly defined and is used in relation to

various perspectives of practice, coupled with the often 'generic', unspecified, utilisation of the concept, brings about a growing frustration amongst some practitioners who argue that the concept has lost its capacity to represent their practice. The various holistic concepts described in the literature in relation to CAM can be placed in two broad categories, that of 'wider self' holism and that of 'wider world' holism, terms Scott (1999) used in her discussion of holism in CAM. I, then, used these two terms to develop a classification of the various holistic concepts that are described in the literature in relation to CAM, and to conceptualise acupuncturists and homeopaths' holistic discourse using this developed framework. By 'wider self' I refer to holistic claims that are described in the CAM literature and which are confined within the individual and her/his immediate environment. This includes the energetic or physiological 'inner working' of patients, their emotional and spiritual 'growth', and the interrelations between these aspects of the individual constitution of the patient. By 'wider world' I refer to three broader holistic categories that are described in the literature. The first is the participatory, empowering nature of the medical encounter that is taking place between the patient and the practitioner. The second involves recognition of an interdisciplinary healthcare and an engagement with other disciplines and other perspectives of ill-health. The third, even broader, is the relationship between patients and their wider environment, and the impact of the social, cultural, political, and geographical environments on the way they live their lives.

Wider self holistic concepts

With no exception, practitioners in my research made frequent reference to matters of wider self holism. This includes the consideration of the interrelations between body, mind and spirit; recognising the body's inherent healing capacity and encouraging this natural ability; the attention in practice to the individuality of patients, their unique biography, and unique constitution; and an emphasis on treating the root cause of health problems, rather than treating symptoms in isolation from the rest of the body. However, as demonstrated in Chapter Five, the expression of such holistic concepts varies between individual practitioners and according to circumstances and audiences. Practitioners appear to express different kinds of 'holisms' and the same practitioner may express different levels

of holistic engagement. There are a number of 'internal' and 'external' factors which influence the degree of holistic engagement of practitioners, and the way that the holistic discourse is narrated. By 'internal' I refer to the nature and style of practice modalities in acupuncture and homeopathy and to practitioners' own practice approach, while by 'external' I refer to political and societal developments around the therapies organisation and practice.

Externally, the professionalisation process drives practitioners to increase their alignment with biomedicine and to adopt findings from biomedical research and RCTs, while dropping (or lowering) esoteric knowledge claims (Cant & Sharma, 1996a; Hollenberg, 2006; Walsh et al., 2004). By that, NMQ acupuncturists and homeopaths, like a number of other allied health and care professions, conform to biomedical dominance in order to achieve greater external legitimacy, albeit reluctantly in some cases (Cant & Sharma, 1995; Saks, 1999; Jackson & Scambler, 2007). Moreover, increased biomedical knowledge is linked with the demarcation of trained, safe and 'knowledgeable' CAM practitioners from untrained ones (Cant, 2009; Welsh et al., 2004). Therefore, we can see the 'narrowing' of the holistic discourse in favour of a degree of alignment with biomedicine as a way of gaining external legitimacy from the medical establishment, from the government and from the public. This can be seen in the way practitioners use RCTs to justify therapeutic strategies and promote their practice on their websites, as well as infuse biomedical terms and concepts when describing acupuncture/homeopathy practice.

At the same time, however, there is certain consumerist demand for the holistic nature of the therapies, and, as pointed out by Welsh et al. (2004), there is a danger that CAM practitioners will see professionalisation as merely an alignment with biomedicine and will lose the holistic ethos that attracted consumers in the first place (Cant, 2009). What often emerged in my study was an intriguing paradox that can be seen in the context of a 'pragmatic holism', by which practitioners narrow or expand their degree of holism according to circumstances. Moreover, it seems as if some practitioners 'mix and match' holistic concepts and biomedical concepts, or use both side by side. For example, practicing both

‘cosmetic acupuncture’ and ‘whole body, holistic acupuncture’, using RCTs to selectively justify certain *elements* of their holistic approach, and providing both an individualistic/constitutional description of practice while placing a list of symptoms that the practitioners specialise in treating, which stand in opposition to the holistic notion of treating *people* and not *conditions*.

The degree of wider self holistic engagement is also influenced by a number of ‘internal’ factors. It is often influenced by the style of practice that is taught at the different schools, which are still heavily influenced by various interpretations of theory and practice of ‘charismatic teachers’. Normally, practitioners in my study adopted a specific practice style, for example Five Elements acupuncture or classical homeopathy, although some combined more than one style of practice. Some acupuncture and homeopathy practice styles are geared more than other styles to treat the root cause of health concerns and consider the individuality of patients and their constitution. From this perspective it seems that a number factors influence the degree of holistic engagement of the practitioner: a) the degree of attention that is given as part of a certain practice style to the personal biography of the patient, b) the freedom of interpretive authority and the degree of reliance on the practitioner’s intuitive skills as part of the diagnostic procedure, c) the willingness of the patient to provide private, intimate information, and d) the personality of the practitioner and her/his desire to adopt such interpretive authority.

For example, it is possible to argue that Stems and Branches acupuncture or classical homeopathy, from a wider self holistic perspective, can be considered more ‘inherently holistic’ than TCM acupuncture or complex homeopathy. Both involve greater emphasis on the personal biography of patients and indicate interpretive freedom and reliance on intuition by the practitioner, more so than some other practice styles. At the same time, however, some practitioners appear to be more comfortable relying on their intuitive skills than others, and some are less comfortable than others in probing into the patient’s intimate, biographic, details. A few practitioners expressed unease with the degree of the practitioner’s ‘emotional intrusiveness’, which, in their view, is part of some approaches to

acupuncture or homeopathy practice. Moreover, some practitioners chose to adopt a dynamic approach in their holistic narration while others adopt a more 'essentialist' approach of 'guarding the purity' of their knowledge, reluctant to change their holistic discourse. This approach seems more characteristic of sections of homeopathy, in line with previous observations of NMQ homeopaths in the UK (Cant & Sharma, 1995) and in Canada (Kelner et al., 2006). Overall, this notion of pragmatic holism can be seen as efforts by NMQ acupuncturists and homeopaths to demarcate themselves from internal competitors and increase their external legitimacy, without losing the holistic appeal of their practice and without alienating their client-base.

Wider world holistic concepts

A number of scholars point at the individualistic nature of CAM, not only in that many CAM practitioners approach patients as unique, placing emphasis on patients' personal biography constitution, but also that this focus on individuals is paralleled with very little acknowledgement of the impact of the broad environment and of life circumstances on peoples' health (Baer, 2003; Coward, 1989; Lowenberg & Davis, 1994). It is evident from the data in this study that, in stark contrast to wider self holistic concepts, practitioners demonstrated very limited awareness of the influence of the broad socio-cultural and geopolitical environments on peoples' health. While both BAcC and SoH recognise the importance of such broader environment issues in their recent practice and educational guidelines, it seems that such awareness is yet to reach the level of individual practitioners in my research study. When practitioners in my research study described 'cases' from their practice, there was hardly any mention or consideration in their narratives, for their patients' living and working conditions, social networks, access to health care, or other cultural or socio economic considerations.

At the same time, such lack of practitioners' orientation to public health concerns is perhaps not that surprising, considering the characteristics of both CAM providers and consumers. Scott (1998) suggests that since most CAM is practiced

in the private sector, it is not in practitioners' economic advantage to locate their treatment in factors that are outside patients' immediate control. Also, as Cant (2009) points out, the fact that CAM is typically practiced by, and consumed in, middle-class areas, suggests geographical inequalities in CAM provision. Moreover, the location of CAM mainly in private practice 'might account for this individualised and personalised service, where the custom of the client must be won rather than assumed' (ibid, p.183). Nevertheless, my argument is that while the lack of awareness of the broad environment by NMQ acupuncturists and homeopaths might be circumstantial and unintended, it is not helpful in increasing practitioners' awareness of the health care environment within which they wish to operate.

There are however three other wider world holistic concerns that the study participants are engaged with more significantly. The main wider world holistic notion that is strongly embedded in practitioners' narratives is the emphasis on democratic and empowering medical encounters. Practitioners were clearly attentive to their patients' point of view, and often emphasised that the centre of the medical encounter is the patient rather than the practitioner her/himself. Some practitioners describe their role as a 'facilitator' or an 'advisor' who works in partnership with the patient. Another wider world holistic concern, which some of the study participants were concerned with, is the limited access to CAM practice, deriving from the fact that it is mostly practiced in the private sector. Indeed, a number of practitioners are offering their services at reduced price through charities, although this does not significantly change the financial nature of CAM practice as a private, rather expensive commodity that not everyone can afford.

In relation to inter-disciplinary healthcare and practitioners' curiosity for other professional perspectives on ill health, the picture is diverse. It seems that interdisciplinary perspective is more naturally adopted by acupuncturists and is promoted by the BAcC and the acupuncture schools. Homeopaths, in contrast, are divided. The SoH, some of the schools, and most of the study participants, perceive interdisciplinary collaboration with other healthcare professionals as an essential part of professionalisation, while a section of the study participants are

not enthusiastic about the prospect of inter-professional exchange or any 'outsiders interference' or influence on homeopathy practice.

The holistic discourse and practitioners' reflectivity

In discussing the medical encounter in CAM, a number of scholars discussed the various challenges and sensitivities that are part of it. Among such unintended challenges is that the holistic discourse may lead to increased medicalisation of people's lives, and that by gaining profound interpretive authority to 'make sense' of patients' personal biography and emotional life, practitioners maintain the same powerful position that is so often argued against in the case of biomedicine (Baer, 2003; Coward, 1989; Crawford, 2006; Goldstein, 2003; Lowenberg & Davis, 1994; Montgomery, 1993). Moreover, by increasing the 'pathogenic sphere', there is a concern that CAM practitioners may, unintentionally, place over-responsibility, and with it feelings of guilt and blame, on their patients. As argued by Gale (2009), the partnership model and the emphasis on democratic, empowering patient-practitioner relationship, involves a potential for psychological and emotional invasiveness which requires reflective awareness of such power relations on behalf of the practitioner.

This concern is linked with the degree of 'interpretive authority' held by the practitioner, as was commonly apparent in my homeopathic participants' narratives, and, to a lesser degree, in several acupuncturists' narratives. It is possible that practice styles that require practitioners to probe into the patient's emotional and psychological biographic details bring about a greater risk for increased interpretive authority. For example, 'classical' homeopathy may involve a greater risk of increased interpretative authority than prescribing 'combinations' homeopathy which is more symptomatic and less 'emotionally intrusive'. This question, of how far should a practitioner go in probing for a patient's personal information, raises ethical dilemmas over the limits of acupuncture or homeopathy practice. Possibly, increased interpretive authority is linked with a certain fluidity of expert knowledge. Both acupuncture and homeopathy practice involve a high level of indeterminacy, in that, like some other CAM, practitioners often rely on

intuition and accumulated practice-experience (Clarke et al., 2004, Hirschkorn, 2006). In the case of homeopathy it is possible that the lack of a clearer, agreed, definition of the scope of expert knowledge, which is part of the 'divisiveness' in homeopathy, adds to this fluidity.

Reflectivity and reflective practice are an increasingly emphasised component of professional education and practice in health and social care, and an essential part of practitioner's professional development (Health Professions Council, 2005, p. 5; Karban & Smith, 2006). *Critical reflection* (Brookfield, 1988) involves contextual awareness of social, historical and cultural contexts and a consideration of unexamined patterns of interaction in practice. Both BAcC (2011) and the SoH (Society of Homeopaths Education Department, 2009), highlight the importance of reflective practice in acupuncture and homeopathy. It is evident from the data that some practitioners are more engaged in critical reflectivity than others. Most striking is the varied attentiveness to the sensitivities that are part of the medical encounter and the degree of interpretive authority held by practitioners. Some practitioners describe, without hesitation, how they take diagnostic and therapeutic decisions that may have significant impact on their patients' emotional and psychological well being, such as in relation to marriage, inter-family relationships, or emotional traumas. In contrast, other practitioners discuss their concern of being 'over-intrusive' or of the nature of practitioner-patient dependency that might develop in the course of treatment. There is a clear recognition by both BAcC and SoH of the importance of reflective practice, and it is possible that the more standardised the acupuncture/homeopathy curricula are, the more such reflectivity is encouraged.

Holism and the challenge of formalising educational structures

In the following section I will highlight the main findings in relation to the following research question:

- How do NMQ acupuncturists and homeopaths negotiate the holistic premise of their practice in the course of formalising their educational structures?
- What is the impact of HEIs on acupuncturists and homeopaths' holistic discourse?

In the past three decades, NMQ acupuncturists and homeopaths have been engaged in formalising their educational structures and standardising their courses by developing training schools and syllabi and attaching these to a set a credentials, in an effort to increase their external legitimacy, and differentiate themselves from 'unqualified', 'unsafe' practitioners (Cant, 2009, Clarke et al., 2004). This process, which includes the infusion of biomedical sciences into the curricula and an increased emphasis on biomedical research and RCTs, paralleled with dropping some of their esoteric claims, involves a number of significant challenges. Among the challenges are disagreements over the degree of biomedical alignment in that process and the fear of losing autonomy over both the content and the delivery of the taught knowledge, as well as the fear of losing the holistic nature of acupuncture/homeopathy practice (Clarke et al., 2004, Kelner et al., 2006, Saks, 2003b). The lack of group cohesion and the inner-divisions in relation to the standardisation process particularly characterised NMQ homeopaths (Cant & Sharma, 1995, Kelner et al., 2006).

A significant development in the therapies' formalisation of education was the entrance of acupuncture and homeopathy courses, since the mid-1990s, into HEIs (Isbell, 2004). This process was backed by the Lords' report (2000), which prompted increased collaboration of the 'big five' CAM with HE. The question is how the formalisation of education is impacted by the involvement of HE in courses' delivery, and how did it affect the therapies' holistic discourse. While nearly all BAcC accredited courses are taught at undergraduate level, in homeopathy there was a significant decrease in such courses, although the SoH expressed commitment to HE standards (Society of Homeopaths Education Department, 2009). What followed is somewhat paradoxical: it seems that HE accelerated the process of standardising acupuncture and homeopathy education,

but at the same time it accentuated the tensions between formal and informal teaching approaches, the debate over the degree of the biomedical alignment, the concern that by reducing indeterminacy in favour of technical knowledge (reducing the I/T ratio, see discussion in pages 73-77 of this thesis) practitioners' autonomy and interpretive authority will be lost, as well the fear that it will increase the transparency of expert knowledge on the account of losing its 'secrecy'.

Interestingly, HE seems to have also sharpened the differences between the professionalisation approach of acupuncturists and that of the homeopaths. If, as Saks (1999) noted over a decade ago, NMQ homeopaths are yet to reach the level of ideological unification of the acupuncturists, the involvement of HE in CAM education only further underlined this point. It seems that in the case of acupuncture these tensions that are part of formalising education were better negotiated, and that acupuncturists adopted a more dynamic approach which considers the benefits as greater than the costs when it comes to formalising education. Moreover, the fact the nearly all BAcC courses are taught at undergraduate level requires a significant degree of codification and standardisation, as in other university courses. It requires acupuncture courses to adhere to standard university procedures, criteria, and guidelines, and standardise both knowledge and teaching.

In any case, reviewing BAcC accredited courses demonstrates a greater degree of cohesion and standardisation of expert knowledge compared with that of SoH accredited courses. This is evident by acupuncture courses' syllabi and courses' content, which include standard provision of medical sciences, biomedical research, as well as defined professional competencies. While HEIs also emphasise the teaching of scientific research and biomedical knowledge, it seems that the private acupuncture schools are able to maintain their unique approach to theory and practice. Indeed, the three acupuncture school principals in my study expressed satisfaction with the degree of holism that they were able to sustain on their courses. The private schools were also able to maintain some of the informal nature of their courses' delivery, and the intimate, personable teaching space in their schools.

The overall approach of acupuncture courses can be described as a detachment between the holistic expression of acupuncture and the process of formalising education. This approach allows NMQ acupuncturists to pursue formalisation, including a significant degree of biomedical alignment, while maintaining the unique nature of esoteric knowledge and the unique practice style of each school. In a way this approach is similar to the strategies adopted by some individual practitioners in negotiating holism and biomedical alignment.
Of course, acupuncture enjoys a degree of 'adoption' by parts of medical and allied to medical professions, and, as I discussed in Chapters Six and Seven, there is a large number of physiotherapists and conventional doctors practicing acupuncture, as well as a significant number of RCTs on acupuncture. While this 'adoption' or integration of acupuncture can be viewed as highly political and as curtailing the holistic nature of acupuncture in favour of biomedical explanatory models (Jackson & Scambler, 2007; Saks, 1999), arguably it also provides traditional acupuncture with some degree of external legitimacy. Possibly, this enabled the HE involvement in acupuncture education to be more favourable than in the case of homeopathy.

Despite the increased status that is attached to HE validation of acupuncture courses, it is clear from my participants' narratives that there are still significant concerns over the degree of biomedical alignment in training. Such concerns were also expressed by acupuncture practitioners and leaders in other studies (Jackson & Scambler, 2007; Welsh et al., 2004). Moreover, as evident from my participant observation, the integration of biomedical knowledge with traditional acupuncture is complex and challenging to both students and staff. The need to consider non-biomedical concepts alongside biomedical ones is complicated to resolve, and students often maintained a negative presentation of the medical profession, and ambivalent feelings in relation to biomedical research evidence. Another challenge is the codification and assessment of highly indeterminate kind of skills that are based on the experience and 'artistic' skills of the acupuncturist. Examples for such un-codified skills are balancing the flow of *qi* or diagnosis according to non-biomedical parameters such as the energetic expression of the patient pulses. At the same time, it was also evident from schools' syllabi as well as from acupuncturists' narratives, that not all practitioners see the process of

biomedical alignment as merely ‘playing the game of biomedicine’ in order to gain external legitimacy. Some practitioners and schools seem to be enthusiastic about this process and genuinely see the integration of traditional acupuncture and biomedical research as fruitful and valuable for the future development of acupuncture knowledge.

In relation to homeopathy, considerable achievements are noticeable during SoH efforts to formalise homeopathy education during times of continuous attack on homeopathy by parts of the government, the media, and from within academia. These attacks mainly portray homeopathy as unscientific, ‘anti-biomedical’, and, as such, irrational and unsuitable to be taught by HEIs. However, homeopaths remain divisive and it seems that many of the challenges that were identified by Cant and Sharma (1995) more than a decade ago, remain. There are still significant gaps between the different schools in relation to the degree of standardisation and formalisation of courses, as well as gaps between the guidelines published by SoH and what the various schools choose to teach. This division is demonstrated by some of the quotes presented earlier and by the rhetoric used by some of the schools which disagree in regard to the role of HEIs as part of formalising their educational content. While most practitioners in this study supported the formalisation of education, hesitant voices expressing concern that it would lead to the loss of autonomy over practice and the loss of the holistic premise were also evident. Unlike in acupuncture, several SoH accredited schools expressed explicit objection to HE involvement in homeopathy education, describing it as an unwanted institutional interference in the freedom of homeopathy teaching. Moreover, several schools, on their websites, point to the technocratic nature of formal education, which, in their view, contradicts the holistic nature of homeopathy.

It seems that the degree to which SoH accredited courses’ syllabi are standardised is extremely flexible to enable each school to maintain its unique approach to the point that the standardisation of education is significantly compromised. The degree of biomedical alignment as well as the teaching of core practice skills differs from school to school. Some schools adopt on idealistic stance of protecting the ‘purity’ of homeopathic knowledge, in contrast to other

schools who adopt a more dynamic approach and are more willing to temper their knowledge claims and infuse biomedical knowledge. If there was a hope by parts of homeopathy that HEIs will drive greater standardisation, the decline in undergraduate homeopathy courses can be seen as a setback.

8.2 Holism as a dynamic discourse in the professionalisation of NMQ acupuncturists and homeopaths: a discussion of the conceptual contribution of this thesis

In the following section I would like to consider my contribution to the conceptual threads that guided my research study, leading to the conceptualisation of holism as a dynamic discourse in the professionalisation of NMQ acupuncturists and homeopaths in the UK. First I would like to consider Scott's (1999) 'paradoxes of holism'. Her work discussed holism in CAM, using a feminist perspective, as a potentially socially and politically progressive reaction against the 'dualistic logic' of biomedicine. Like several other authors (for example Crawford, 2006; Lowenberg & Davis, 1994), while pointing at the importance of the holistic perspective, she presented some limitations to this discourse as an anti-oppressive model. Scott's work develops a structured, critical discussion on the nature of the holistic discourse in CAM. In particular, I found her terms 'wider self' and 'wider world' holism helpful in pointing to the tension between, on the one hand, the individualistic, 'inward nature' of many CAM, and the lack of awareness regarding the relationship of people and their broader environment on the other. While referring to three holistic models, the 'biographical expressive', the 'ecological/public health', and the 'spiritual' model, she points out that the public health model is intensively holistic (and as I added in Chapter Two, in particular the 'broad' rather than the 'narrow' model of public health), in that it emphasises social exclusion and environmental concerns, rather than remaining confined to the individualistic focus of many CAM.

The public health model, which enables conventional doctors to practice more holistically, received very little attention in my participants' narratives. My argument, which I will discuss further in relation to figure 10 on page 287, is that the extension of the holistic scope in CAM to such public health concerns, which may be developed in HE courses, has the potential to increase the scope of the holistic discourse in acupuncture and homeopathy. Moreover, it might help practitioners develop greater awareness of the mainstream environment in which many of them wish to operate, and tap into an area of mainstream practice that is not strictly biomedically-focused.

While Scott's point of departure in conceptualising holism is in the context of a reaction against biomedicine's dualistic logic, I extended Scott's discussion to examine what happens to the holistic discourse during the dynamic process of 'mainstreaming' of CAM, and how practitioners negotiate holism during this process. In my thesis, the holistic discourse is considered in relation to dynamic political changes, i.e. professionalisation and formalisation of CAM education. In other words, I examined holism during a process of biomedical alignment, the infusion of biomedical concepts into CAM education, and the changing relationship between CAM and biomedicine, which generate tensions and 'threats' to the nature of the holistic discourse. Such examination required an exploration of *practitioners' perceptions of holism* and their holistic narration. Moreover, the 'starting point' of holism as a reaction against biomedicine's dualistic logic, does not take into account the historical nature of some CAM, including acupuncture and homeopathy, which are often described as 'inherently holistic' (Fulder, 1996; Goldstein, 1999) in relation to cultural and historical perspectives. For example, it is argued that therapies such as acupuncture and homeopathy maintain certain characteristics of the ancient Hippo-Galenic principles of medicine (Bates, 2002). I, therefore, extended the exploration of 'wider self' holism to claims that stem from the historical evolvement of acupuncture and homeopathy, such as 'promoting the inherent healing capacities of the body' and 'treating the root cause'. I also used the term 'wider world' holism beyond the focus on the public health model, to include an inter-disciplinary healthcare and provide a more

detailed categorisation of wider world holistic claims.

In order to consider the holistic discourse during the formalisation of acupuncture and homeopathy education, in Chapter Three I discussed the process of formalising education in the context of Witz's (1990) model of occupational closure. On a number of occasions throughout the thesis, I located practitioners' strategies and their ways of negotiating holism and formalising education in relation to closure strategies: first, in discussing the formalisation of education as a form of social closure by NMQ acupuncturists and homeopaths (Cant, 2009; Saks, 1999), including the development of training schools and syllabi and the efforts to unify the disparate groups of practitioners under the BAcC and SoH; and second, in relation to the inclusion of medical sciences in training and the tempering of knowledge claims. Then, closure strategies are considered when discussing the way practitioners negotiate the tension between formalising their education and maintaining their holistic ethos, which I described as 'pragmatic holism'.

The perspective of closure strategies is useful in presenting the dilemma that NMQ acupuncturists and homeopaths face between holism and formalising education. As Saks (2003b) points out, central to this perspective is 'the emphasis given to the fluidly changing boundaries between professions and other occupational groups' (p. 224), and where CAM is defined not so much on the base of its philosophies as by its political marginalisation in relation to biomedicine. The formalisation of education of NMQ acupuncturists and homeopaths can be seen as a strategy of inclusion into the mainstream and increasing the therapies' external legitimacy. The standardisation of expert knowledge may help distance practitioners from 'unqualified practitioners' and get lay, medical and state legitimacy, although, as some of the literature suggest, the degree to which this really happens is limited, leaving CAM in a position which is described by Cant (2009) as 'mainstream marginality'. The tension is between, on the one hand, becoming professionalised and formalised, thus more transparent, in an effort to increase the therapies external legitimacy and societal status, and,

on the other, protecting the holistic expression, the 'mystique' and secrecy of practice. Closure strategy in this case helps explain the relationships between knowledge claims of occupations as a way of determining their jurisdictional boundaries (Welsh et al., 2004), and the way in which aligning acupuncture and homeopathy education with biomedicine increases the therapies' prospect of gaining social closure.

However, from the perspective of social closure, formalising education can be seen as promoting occupational self-interest rather than an altruistic concern for the broader public (Saks, 1999). Developing the practitioner's position as 'expert', through the standardisation of CAM training, increases the practitioner/patient gap (Cant, 2009; Saks, 1999). This stands against the holistic aspiration of many CAM to maintain a more egalitarian patient-practitioner relationship. Boon et al. (2004) point at the usefulness as well as the limits of the social closure perspective: while some degree of social closure takes place during self-regulation and formalising education by CAM professions, it will not necessarily create a monopoly position. As Cant et al. (2011) point out, social closure does not explain the way certain groups continue to pursue professionalism when formal reward is not granted, as in CAM's position of 'mainstream marginality'.

Moreover, although the social closure model is helpful in explaining some of the success of CAM therapies in working towards professional status, it is limited in explaining the interaction and dynamics *within* professions (Adams, 1998, cited in Boon et al., 2004). As argued by Almeida (2012), sociological research on CAM tends to underestimate issues of internal heterogeneity within CAM. Therefore, while I have used Witz's model and the perspective of social closure to consider the dilemmas and complexities between the holistic discourse of NMQ acupuncturists and homeopaths and the formalisation of education, I have moved beyond this model by exploring the position *of individual practitioners* and the *internal dynamics* of their' practices. Such internal dynamics can be considered at different levels, including the diversity of practice approaches and theories within CAM therapies, and of individual practitioners' approaches in different practise

settings. Moreover, since the majority of practitioners practice privately, they are required to develop strategies themselves to negotiate both external political challenges and internal challenges from within practice, which I considered in this research study as ‘pragmatic holism’.

Moreover, while reflecting on Witz’s model, arguably, the model lacks greater consideration for the challenge of CAM to ‘open up’ to an environment that is dominated by biomedicine. Social closure refers to the way occupations seek to regulate market conditions in their favour, minimising competition from others by employing strategies which restrict access to a limited group (Parkin, 1974). My argument is that part of the challenge of professionalisation in the case of CAM is ‘to open up’ to other professional perspectives and to engage with other professionals in the health care environment. The difficulty is, as pointed out by Saks (2003b), that social closure reflects the political nature of the marginalisation of CAM and its subordination to biomedicine. ‘Mainstreaming’ CAM involves engaging with an environment that is dominated by biomedicine, as well as working with a number of health occupations that gained a professional standing at the expense of being formally subordinated to biomedicine (Saks, 1999). While closure strategies highlight the way that NMQ acupuncturists and homeopaths shed some of their ‘holistic identity’ in order to gain external legitimacy and increase their societal status, it seems to lack a discussion on how both therapies are engaged in a positive exchange of knowledge and interaction with other healthcare professions.

For example, while there is infusion of biomedical knowledge into CAM education, in my thesis I have also described a degree of ‘diffusion’ of CAM into physiotherapy practice, where physiotherapists may use concepts from traditional acupuncture when describing their acupuncture practice to their patients, albeit restricted in its ‘holistic expression’. It seems, from the small number of narratives I conducted with members of the AACP, that some physiotherapists are genuinely enthused about acupuncture concepts and theory, regardless of their strong belief in biomedicine. At the same time I have also interviewed acupuncturists and homeopaths who are genuinely interested in human biology and in biomedical concepts and are looking, out of genuine interest, to identify parallels between

biomedical and non-biomedical explanatory models to their practices. Another example for such positive dialogue between CAM and mainstream health-care professionals can be seen in the views of leaders of the public health movement, some of whom identified a degree of overlap and potential space for mutual collaboration between CAM and public health (Hill, 2003). Amongst the overlapping concepts that were identified between CAM and public health, are the mutual focus on 'salutogenic[43]' approach and enhancing health and well-being, the empowering of patients, and placing emphasis on the spiritual dimension of health. At the same time, the public health movements' focus is on individual and communities' broad environment, which, as discussed in this thesis, receives little attention by CAM practitioners.

In figure 10, below, I propose a model which considers holism as a dynamic discourse in the formalisation of NMQ acupuncturists' and homeopaths' education. The figure describes the relationship between the holistic discourse and formalising the therapies' education, and the potential of holism, as a dynamic discourse, to enhance the therapies' interdisciplinary exchange with other health care professions:

[43] Coined by Antonovsky, the term "salutogenesis" means focusing on factors that *support* human health and well-being, rather than on the factors that are *causing* the disease.

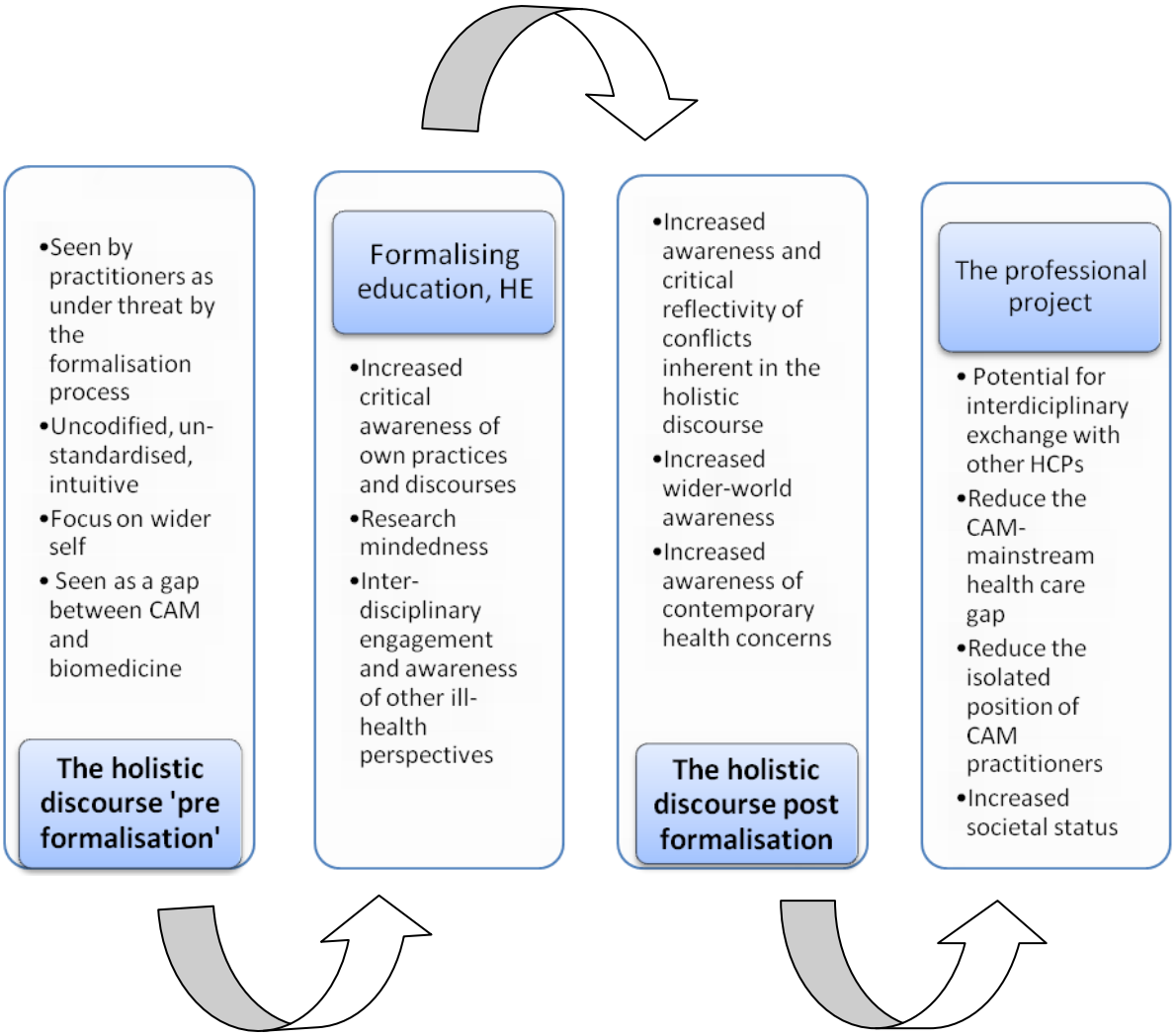


Figure 10: Holism as a dynamic discourse in the professionalisation of acupuncture and homeopathy

As discussed in this thesis, the efforts of BAcC and SoH to professionalise and to formalise their courses, involves a degree of alignment to biomedicine and the 'lowering' of esoteric claims, in order to try gaining external legitimacy, increase practitioners' societal status, and demarcate themselves from 'untrained' practitioners. This process involves the standardisation of expert knowledge and with it a threat to the holistic ethos of the therapies, the 'secrecy' of esoteric knowledge, and the interpretive autonomy of the practitioner. The holistic discourse here is at the centre of the tension between 'protecting the purity of expert knowledge' and the process of standardising this knowledge and its alignment with biomedicine.

However, I propose that, somewhat paradoxically, formalising education can contribute to increasing important elements of the holistic discourse of acupuncture and homeopathy, rather than only 'lowering' it. During the formalisation of education, and in particular when HEIs are involved, there is a potential, as my findings show, to develop practitioners' critical reflectivity in relation to their own practices and in relation to the holistic discourse. Moreover, the interaction with other disciplines and professionals in the healthcare domain, which often takes place in faculties and schools at HE, can lead to developing the current individualistic focus of the holistic discourse in acupuncture and homeopathy to greater wider world awareness.

As I discussed earlier in this section, potential overlap in both ideology and practice between certain CAM therapies and public health and health promotion were identified in Hill's (2003) research study, although a concern was expressed in relation to the individualistic focus of CAM and the lack of engagement with the broad environment. The interaction of NMQ acupuncturists, and to a lesser degree of homeopaths, with other disciplines such as psychology, public health, social work, physiotherapy, operating department practice and others, which in some cases sit alongside the therapies in university faculties and schools, may lead to a dialogue, in relation to health care delivery. Such interaction has the potential to increase discussions by acupuncturists and homeopaths on the broad environment of patients, and there are already some examples for such development in acupuncture courses. Amongst the academic units that are currently taught at undergraduate acupuncture courses there are several units which cover topics such as 'an appreciation and understanding of the major debates in health-care with particular reference to concerns in [name of city]'; 'concepts of inter-professional practice in health and social care'; 'exploring the perspective of health and illness, which embraces the interaction of bio-medical, psycho-social and cultural influences'; and 'health and social care research'.

Finally, I would like to consider the way my thesis was informed by Jamous and Pelloile's (1970) work on knowledge indeterminacy. I build on this work to develop the discussion over the unique nature of the expert knowledge in acupuncture and homeopathy and, in particular, the holistic discourse, and the complexity of standardising this kind of knowledge in the process of formalising the education of these two therapies. Their work centres on the way that the professionals' specialised knowledge creates the social distance between the expert/practitioner and the patient, who is excluded from the esoteric knowledge of the profession. A high I/T ratio enables members of a profession to claim professional judgement beyond the scrutiny of the lay public (Macdonald, 1995). However, while professions have a need for a body of formal rational knowledge, which can be codified and standardised, this process of formalising and standardising education makes this knowledge more accessible to 'externals', which may undermine the privileged position of the profession. Therefore, formalising acupuncture and homeopathy education means that the therapies' expert knowledge will be more standardised and less exclusive. This, in turn, may help distance practitioners from 'unqualified practitioners' and may help get lay, medical and state legitimacy. The process of formalising CAM education, and the biomedical alignment that is part of it, involves both the subordination of CAM to biomedicine, as well as threatens the 'secrecy' of the profession and the degree of autonomy and 'interpretive authority' of the acupuncturist/homeopath. This perspective helps demonstrate the challenge that practitioners face during the formalisation of their education: on the one hand the desire to gain increased recognition as both experts and safe practitioners and to gain a degree of 'mainstream credibility', but at the same time having to find strategies to maintain the holistic nature of practice and maintain a degree of both 'secrecy' and 'interpretative authority', as well as maintain the unique appeal of their practice.

Therefore, as I have demonstrated in this thesis, NMQ acupuncturists and homeopaths adopt a dynamic approach whereby they shift between emphasising the indeterminacy inherent in their practice through their holistic discourse, and emphasising the technical knowledge that they gain through, for example, human biology and standardised RCTs. This dynamic approach is challenging, and this is in particular apparent at the level of schools, when courses are delivered by, or

validated by, HEIs, which prompt greater knowledge codification and standardisation. As I showed in my participant observation, acupuncture students found the integration of their 'own' esoteric knowledge, difficult to place alongside biomedical concepts. Moreover, although not unique to CAM, the high I/T ratio in acupuncture and homeopathy, makes it difficult to assess diagnostic and clinical skills, such as managing *qi* or prescribing a homeopathic remedy.

It has been a relatively short period since acupuncture and homeopathy entered HEIs. Nevertheless, despite the biomedical alignment that is taking place in BAcC and SoH courses, and despite the increased process of standardisation and formalisation of those courses, developing the holistic discourse in the direction of 'wider world' has the potential to identify and develop areas of interface with other health-care professions.

8.3 Methodological contribution

At the beginning of this chapter I have discussed the use of a number of methodological strategies to enhance the transferability of my findings through the sampling approach, working towards saturation in data analysis, building on research that was conducted previously with similar groups in similar or different settings, using conceptual threads to guide my data analysis, and using a mixed-method, in-depth qualitative approach, to move towards a 'thicker description'. There are two other methodological perspectives which enhanced the value of this research study.

First, by adopting an in-depth qualitative methodology and employing data from several resources, including interviews, websites and document review, and participant observation, I was able to achieve several benefits in relation to my research questions. CAM practitioners have been criticised in the past for not engaging enough in self-critique, for not developing 'healthy self scepticism' (Peters, 1998; Vickers, 1998), and for failing to address the issues and tensions that accompany their holistic discourse (Birch, 1998; Peters, 1998; Pietroni, 1997, p. 9). The in-depth qualitative nature of this research study presented practitioners

with an opportunity to participate in a critical discussion of the challenges that are part of their holistic discourse as well of the professionalisation of their practice. The presentation of a significant amount of data derived from practitioners' narratives contributed to bringing their perspectives to the fore. In doing so, the research allowed participants to share the discussion, rather than being mere passive subjects of my own conceptualisation of their discourses and practices.

Second, due to the time that the research took to complete and the constantly changing research scene, there was a need to adopt a flexible data collection approach. Moreover, the field of inquiry is shaped by several 'actors', including practitioners, their professional bodies, their schools, political agencies, and HEI's, and this context called for a dynamic rather than an essentialist research approach which allowed me to respond to changes in the field. Relying on several sources of data enabled me to achieve a rounded perspective encompassing several angles in the context of the research questions and in the context of the conceptual threads which guided the research.

8.4 Limitations of the research

I have already discussed in this chapter the location of NMQ acupuncturists and homeopaths mostly in the private sector and the way this may have affected practitioners' 'holistic narration' and holistic discourse. Another limitation of my research was the difficulty to achieve greater engagement from homeopaths in discussing the formalisation of their education. Mainly, I refer to the difficulty to engage homeopathy schools and educators with the research. This, to a degree, limited my ability to obtain better insight into the way homeopathy schools negotiate the challenges that are part of the formalisation of education, and in particular their holistic discourse. Nevertheless, it was possible to obtain significant data from the information published by schools on their websites as well as from the courses' syllabi I was provided with. During the interview period, between 2007 and 2009, homeopathy was under heavy attack in the media, from the House of Commons committee investigating NHS provision of homeopathy, and from researchers and academics who opposed the teaching of homeopathy

on HEIs courses. It is possible that, therefore, homeopathy practitioners and educators were suspicious, hesitating to take part in research which examines their professional outlook. It is also possible that the presence of a CAM research group at the neighbouring University of Southampton, conducting research projects with homeopaths, resulted in a certain level of saturation amongst homeopaths in relation to participation in research. In any case, I was unable to secure a participant observation in one of the homeopathic schools, which could then have been used as a comparison with my acupuncture participant observation. Bearing this limitation in mind, I argue that the range and depth of the data gathered altogether, did compensate for many of the limitations mentioned.

I also recognise that while the information gathered from the professional bodies and the schools reflects a UK perspective, the data that was gathered from interviews and from observations took place in a confined geographic area in London and the South of England. This, arguably, may present a highly geographically-contextual picture which may differ from other geographic areas in the UK. My argument in relation to this point is that data from interview narratives and observations was interwoven with the rest of the data that as gathered in this research study in a way that allowed me to describe the research in a broader geographical context rather than 'the South East of England'.

8.5 Recommendations for further research

Some of the processes explored in this thesis have implications for disciplines outside the CAM domain. The professionalisation and formalisation of educational structures and the need to negotiate indeterminate and technical kinds of knowledge are not challenges that are confined to CAM. In the past decade several professional groups in the field of health and social care have gone through similar professional projects. These professional projects involve formalisation of educational structures, and, in many cases, involve HEIs in the delivery of education (Emms & Armitage, 2010; Orme et al., 2009; Timmons, 2010). For example paramedics, operating department practitioners, speech and language therapists, and social workers have all moved from professional in-

house training which matches their previous position as an *occupation,* to university courses which match a *professional* status. These groups experience some similar challenges, despite their more mainstream status. Relying on intuition and experience in practice and the challenge of standardising such skills in education is a challenge which other professions, such as paramedics (Wyatt, 2003) and social workers (Cameron, 2004, cited by Hatton, 2008, p. 116) face. It would be of value to compare the professional journey of acupuncture, homeopathy, and other CAM, with that of other, non-CAM, professions, and how different kinds of knowledge are negotiated during the formalisation of knowledge in HEIs.

More intrinsic to this research is extending the exploration of the way that indeterminate knowledge is currently assessed during acupuncture and homeopathy courses and how highly indeterminate knowledge, such as balancing *qi*, is measured. Such an examination requires close and perhaps prolonged observation of teaching and learning in acupuncture and homeopathy schools, and requires linking teaching with clinical examination of students' skills. It would be particularly useful to compare this evaluation of indeterminate-in-nature clinical competencies between HEIs and the private schools' courses. Another potential extension to the research follows on from Sharma's discussion of building a professional community and a collective culture in homeopathy (Sharma, 1996). It seems to me that there are significant differences between acupuncturists and homeopaths in the way that they communicate, interact, and negotiate professional matters with one another. Acupuncturists, it seems to me, are more cohesive, united and purposeful in their professional actions, although this is a rather superficial observation that requires further research. I am curious as to what degree the professional culture and professional identity of the therapies are influenced by their outward public image and vice versa. I often wonder how the frequent attacks on homeopathy affected its professional culture and its attitude towards the professional project.

8.6 Concluding comments

Throughout this thesis I considered the holistic discourse of NMQ acupuncturists and homeopaths as a dynamic discourse, in that it is influenced by political and societal developments around acupuncture/homeopathy practice, as well as from within the therapies themselves. The thesis demonstrated how practitioners 'narrow' or 'expand' their holistic narratives and practices as part of negotiating the challenges associated with formalising their education, as well as those encountered during the professionalisation process. The holistic discourse of acupuncture and homeopathy is an essential part of the therapies' professional project and their professional future. It is interwoven in the therapies' philosophy, theory and practice. Nevertheless, practitioners often negotiate the tension between increasing formalisation and the unique nature of their expert knowledge, by using a sort of 'pragmatic holism', to try and make gains from the formalisation process, without losing the 'holistic appeal' of their practice to their consumers. While there are differences in the degree of standardisation and commitment to the process of formalising education in acupuncture and homeopathy, it seems that the increased formalisation that comes with the involvement of HEIs in courses' delivery (or the aspiration to follow 'HE standards') by BAcC and SoH, brings both strains and opportunities to the therapies' holistic discourse. On the one hand it accentuates the tensions between maintaining the unique nature of expert knowledge and degree of practitioners' interpretive autonomy, and the degree of standardisation and of biomedical alignment in acupuncture/homeopathy courses. However, HE may contribute to increasing the holistic discourse of practitioners and schools towards wider world holism, increase practitioners' critical reflectivity in relation to this discourse, and possibly, increase practitioners' exchange of perspectives over healthcare with other health and care disciplines.

References

Acupuncture Association of Chartered Physiotherapists. (2008). *Welcome to AACP*. Retrieved April 8, 2010, from http://www.aacp.uk.com

Acupuncture Association of Chartered Physiotherapists. (2009). *AACP background.* Retrieved August 14, 2009, from http://www.aacp.uk.com/common/about.asp?ID=aacp

Acupuncture Association of Chartered Physiotherapists. (2010). *What is acupuncture?* Retrieved February 14, 2012, from http://www.aacp.org.uk/index.php?option=com_content&view=article&id=51&Itemid=105

Acupuncture Association of Chartered Physiotherapists. (2011). *AACP background*. Retrieved 1 August, 2012, from http://www.aacp.org.uk/index.php?option=com_content&view=article&id=55&Itemid=67

Adams, J. (2007). Introduction. In J. Adams (Ed.), *Researching Complementary and alternative medicine.* London: Routledge.

Adams, J., & Tovey, P. (2008). Introduction: towards a critical social science of CAM in nursing and midwifery. In J. Adams, & P. Tovey (Eds.), *Complementary and alternative medicine in nursing and midwifery: Towards a critical social science* (pp. 1-8). London: Routledge.

Alford, R.R. (1975). *Healthcare politics – ideological and interest group barriers to reform.* Chicago: The University of Chicago Press.

Allan, K. (2006). *Contemporary social and sociological theory.* London: Pine Forge Press.

Almeida, J. (2012). The differential incorporation of CAM into the medical establishment: The case of acupuncture and homeopathy in Portugal. *Health Sociology Review, 21*(1), 5-22.

Alternative therapy degree attack. (2007). Retrieved November 8, 2011, from the BBC news website: http://news.bbc.co.uk/1/hi/6476289.stm

Anekwe, L. (2010, May 19). BMA leaders hit out at homeopathy 'witchcraft'. *Pulse.* Retrieved October 28, 2011, from http://www.pulsetoday.co.uk/story.asp?storycode=4126047

Argil, K. (2006). Chinese Medicine. In M. Micozzi (ed.), *Fundamentals of Complementary and Integrative Medicine* (pp. 375-417). St. Louis: Elsevier Saunders.

Atkinson, P., & Hammersley, M. (1995). *Ethnography: principles in practice.* New York: Routledge.

Atkinson, P., & Hammersley, M. (1998). Ethnography and participant observation. In N.K. Denzin, & Y.S. Lincoln, (Eds.), *Strategies of qualitative inquiry* (pp. 111-136). London: Sage.

Baer, H., Hays, J., McCLendon, N., McGoldrick, N., & Vespucci, R. (1998). The holistic health movement in the San Francisco bay area: Some preliminary observations. *Social Science & Medicine, 47*(10), 1495-1501.

Baer, H. (2003). The work of Andrew Weil and Deepak Chopra – two holistic health/New Age gurus: A critique of the holistic health/New Age movements. *Medical Anthropology Quarterly, 17*(2), 233-250.

Barry, C. (2002, May). Identity/identities and fieldwork: Studying homeopathy and Tai Chi 'at home' in South London. *Anthropology Matters,* 2002. Retrieved 23 May, 2007, from http://www.anthropologymatters.com/journal/2002/barry2002_identity.htm

Barry, C. (2006). The role of evidence in alternative medicine: Contrasting biomedical and anthropological approaches. *Social Science and Medicine, 62* (2006), 2646–2657.

Bates, D. (2002). Why not call modern medicine 'alternative'? *Annals of American Academy of Political and Social Sciences, 583*(1), 12-28.

Bellavite, P., Conforti, A., Piasere, V., & Ortolani, R. (2005). Immunology and Homeopathy. 1. Historical background. *eCAM, 2*(4), 441-452.

Birch, S. (1998). Diversity and acupuncture: Acupuncture is not a coherent or historically stable tradition. In A. Vickers (Ed.), *Examining complementary medicine* (pp. 45-63). Cheltenham: Stanley Thornes.

Bishop, F., Zaman, S., & Lewith, G. (2011). Acupuncture for low back pain: A survey of clinical practice in the UK. *Complementary Therapies in Medicine, 19*(3), 144-148

Bivins, R. (2001). The needle and the Lancet: Acupuncture in Britain, 1683-2000. *Acupuncture in Medicine, 19*(1), 2-14.

Bodeker, G., & Burford, G. (2007). *Traditional, complementary and alternative medicine: Policy and public health perspectives.* London: Imperial College Press.

Boon, H., Welsh, S., Kelner, M.J., & Wellman, B. (2004). CAM Practitioners and the Professionalisation Process: A Canadian Comparative Case Study. In P. Tovey, G. Easthope, & J. Adams (Eds.), *The Mainstreaming of Complementary and Alternative Medicine: Studies in Social Context* (pp. 123-139). London: Routledge.

Boseley, S. (2009, June 10). Critics find NHS's £12m spend on homeopathy hard to swallow. *The Guardian Online.* Retrieved June 19, 2009, from http://www.guardian.co.uk/society/2009/jun/10/complementary-medicine-nhs-more4

Bradley, R. (2006). Philosophy of naturopathic medicine. In J. Pizzorno & M. Murray (Eds.), *Textbook of natural medicine,* (pp. 79-87). St Louise: Churchill Livingstone, Elsevier.

British Acupuncture Accreditation Board. (2008). *Training.* Retrieved November 10, 2010, from http://www.baab.co.uk/Accreditedcourses.html

British Acupuncture Accreditation Board. (2010). *Accreditation handbook.* London: British Acupuncture Accreditation Board.

British Acupuncture Accreditation Board. (n.d.). Retrieved October 1, 2011, from http://baab.co.uk/general-public.html

British Acupuncture Council. (2000). *Guidelines for Acupuncture Education.* London: British Acupuncture Council.

British Acupuncture Council. (2004). *BAcC Code of Professional Conduct.* London: British Acupuncture Council.

British Acupuncture Council. (2007). *What is traditional acupuncture?* Retrieved July 5, 2007, from http://www.acupuncture.org.uk/acupuncture

British Acupuncture Council. (2009a). *The standards of practice of acupuncture.* British Acupuncture Council.

British Acupuncture Council. (2009b). *Welcome to the British acupuncture Council.* Retrieved August 14, 2009, from http://www.acupuncture.org.uk/

British Acupuncture Council. (2011). *Standards of Education and Training for Acupuncture.* London: British Acupuncture Council

British Educational Research Association. (2009). *Interpretivist research strategies: Ethnography.* Retrieved September 20, 2009, from http://www.bera.ac.uk/interpretivist-research-strategies/interpretivist-research-strategies-ethnography/#references

British Homeopathic Association. (2010). *BMA detailed comments on the recommendations of the Science & Technology Committee's 'Evidence Check 2: Homeopathy'.* Retrieved October 28, 2011, from http://www.facultyofhomeopathy.org/export/sites/faculty_site/ST_parts_1-6.pdf

British Medical Acupuncture Society. (2011). *Diploma of medical acupuncture.* Retrieved July 4, 2012, from http://www.medical-acupuncture.co.uk/LinkClick.aspx?fileticket=EOJyE-4jqoc%3D&tabid=64

British Medical Acupuncture Society. (n.d.). *About BMAS.* Retrieved July 31, 2011 from http://www.medical-acupuncture.co.uk/about/

Brookfield, S. (1988). Developing critically reflective practitioners: A rationale for training educators of adults. In S. Brookfield (Ed.), *Training educators of adults: The theory and practice of graduate adult education* (pp. 317–338). London: Routledge.

Byrne, B. (2004). Qualitative interviewing. In C. Seal, (Ed.), *Researching society and culture* (pp. 180-191). London: Sage.

Cant, S. (1996). From Charismatic teaching to professional training: The legitimating of knowledge and the creation of trust in homoeopathy and chiropractic. In T. Heller, G. Lee-Treweek, J. Katz, J. Stone, & S. Spurr (Eds.), *Perspectives on complementary and alternative medicine: A reader* (pp. 222-230). London: Routledge.

Cant, S. (2009). Mainstream marginality: 'Non-orthodox' medicine in an 'orthodox' health service. In J. Gabe, & M. Calnan (Eds.), *The new sociology of health service* (pp. 177-200). London: Routledge.

Cant, S., & Calnan, M. (1991). On the margins of the medical market place? An exploratory study of alternative practitioners' perceptions. *Sociology of Health and Illness, 13*(1), 39-57.

Cant, S., & Sharma, U. (1995). The reluctant profession – homeopathy and the search for legitimacy. *Work, Employment & Society, 9*(4), 743-762.

Cant, S., & Sharma, U. (1996a). Demarcation and transformation within homeopathic knowledge. A strategy of professionalism. *Social Science & Medicine, 42*(4), 579-588.

Cant, S., & Sharma, U. (1996b). Professionalisation of complementary medicine in the United Kingdom. *Complementary Therapies in Medicine, 43*(3), 157-162.

Cant, S. & Sharma, U. (1999). *New medical pluralism? Alternative medicine, doctors, patients and the state.* London: UCL Press.

Cant, S., Watts, P., & Ruston, A. (2011). Negotiating competency, professionalism and risk: The integration of complementary and alternative medicine by nurses and midwives in NHS hospitals. *Social Science & Medicine*, *72*(4), 529-536.

Carlston, M. (2006). Homeopathy. In M. Micozzi (ed.), *Fundamentals of Complementary and Integrative Medicine* (pp. 95–110). St. Louis: Elsevier Saunders.

Cassidy, C. (2006). Social and cultural factors. In M. Micozzi (Ed.), *Fundamentals of complementary and alternative medicine (pp. 27-52).* St. Louise: Sounders, Elsevier.

Chatwin, J. (2009). Activity transitions in the homeopathic therapeutic encounter. *The Sociological Review, 57*(1), 163-185.

Clarke, B., Doel, A. & Sergott, J. (2004). No alternative? The regulation and professionalization of complementary and alternative medicine in the United Kingdom. *Health and Place, 10*(4), 329-338.

College of Paramedics. (n.d.). *About us.* Retrieved February 12, 2012, from https://www.collegeofparamedics.co.uk/about_us/

Colquhoun, D. (2007). Science degrees without the science. *Nature, 446*(22), 373-374.

Colquhoun, D. (2008, August 29). Regulating quack medicine makes me feel sick. *The Times Online.* Retrieved June 19, 2009, from http://www.timesonline.co.uk/tol/comment/columnists/guest_contributors/article4628938.ece

Cook, H. (1997). From the scientific revolution to the germ theory. In I. Loudon (Ed.), *Western medicine: An illustrated history* (pp. 80-101). Oxford: Oxford University press.

Corbyn, Z. (2008, October 30). Unwelcomed complements. *The Times Higher Education.* [On line]. Retrieved November 10, 2010, from http://www.timeshighereducation.co.uk/story.asp?storycode=404104

Corbyn, Z. (2009, April 9). Recruitment problems kill off CAM courses. *The Times Higher Education.* [On line]. Retrieved November 10, 2010, from http://www.timeshighereducation.co.uk/story.asp?storycode=406111

Coulter, I. (2004). Integration and paradigm clash: The practical difficulties of integrative medicine. In P. Tovey, G. Easthope, & J. Adams (Eds.), *The mainstreaming of complementary and alternative medicine* (pp. 104-122). London: Routledge.

Coward, R. (1989). *The whole truth: The myth of alternative medicine*. London: Faber and Faber.

Crawford, R. (2006). Health as a meaningful social practice. *Health, 10*(4), 401-420.

Creswell, J. (1997). Qualitative Inquiry and Research Design. London: Sage.

Denscombe, M. (2007). *The good research guide for small-scale social research projects* (3rd ed.). Maidenhead: Open University Press.

Denzin, K., & Lincoln, Y. (2003). Introduction: The Discipline and practice of qualitative research. In N. Denzin, & Y. Lincoln (Eds.), *Collecting and interpreting qualitative material* (pp. 1-46). London: Sage.

Department of Health. (2011). *Analysis report on the 2009 consultation on the statutory regulation of practitioners of acupuncture, herbal medicine, traditional Chinese medicine and other traditional medicine systems practised in the UK*. [electronic version]

Eysenbach, G., & Till, J. (2001). Ethical issues in qualitative research on internet communities. *BMJ, 323*(7321): 1103–1105.

Emms, C. & Armitage, E. (2010). Paramedic training and higher education: A natural progression? *Journal of Paramedic Practice, 2*(11), 529-533.

Ehrenreich, B., & English, D. (1978). *For Her Own Good: Two Centuries of the Experts Advice to Women.* New York: Anchor Press.

Ernst, E. (2007). Exploring homeopathy. *Preventative Medicine, 45*(4), 280-281.

Ernst, E., & Schmidt, K. (2004). Homotoxicology – a review of the clinical trials. *European Journal of Clinical Pharmacology*, *60*(5), 299-306.

European Traditional Chinese Medicine Association. (2010). *British Acupuncture Council.* Retrieved April 8, 2010 from http://www.etcma.org/content/view/31/43

Evetts, J. (2006). Short note: the sociology of professional groups. *Current Sociology*, 54(1), 133-143.

Faculty of Homeopathy. (2010). *Training*. Retrieved May 5, 2010, from http://www.facultyofhomeopathy.org/training/

Faculty of Homeopathy. (2011). *NHS referrals*. Retrieved 28 April, 2010, from http://www.facultyofhomeopathy.org/media/facts_about_hom/nhs_referrals.html

Firestone, W. (1990). Accommodation: towards a paradigm-praxis dialectic. In E. Guba (Ed.), *The paradigm dialog* (pp. 105-124). Newbury Park: Sage.

Flick, U. (2006). *An introduction to qualitative research.* London: Sage.

Fontana, A., & Frey, J. (2003). The interview, From structured questions to negotiated text. In N.K. Denzin, & Y. S. Lincoln, Y.S. (Eds.), *Collecting and interpreting qualitative materials* (pp. 61-106). Thousand Oaks: Sage.

Fournier, V. (1999). The appeal to professionalism as a disciplinary mechanism. *The Sociological Review, 47*(2), 280-307.

Freidson, E. (1970). *Profession of Medicine*. A study of the sociology of allied knowledge. New York: Harper and Row.

Frohock, F. (2002). Moving lines and variable criteria: Differences/connections between allopathic and alternative medicine. *The ANNALS of the American Academy of Political and Social Sciences, 583*(1), 214-232.

Fulder, S. (1996). *The handbook of alternative and complementary medicine.* Oxford: Oxford University press.

Fulder, S. (2005). The basic concepts of alternative medicine and their impact on our views of health. In G. Lee-Treweek, T. Heller, S. Spurr, H. MacQueen, & J. Katz (Eds.), *Perspectives on complementary and alternative medicine* (pp. 3-8). London: Routledge.

Furnham, A., & Vincent, C. (2003). Reasons for using CAM. In Kelner, M., & Wellman, B. (Eds.) *Complementary and Alternative Medicine: Challenge and Change* (pp.61-78). London: Routledge.

Gale, N. (2007). *Knowing the body and embodying knowledge: an ethnography of student practitioner experiences in osteopathy and homeopathy*. Unpublished doctoral thesis; Warwick University.

Gale, N. (2009). Promoting patient-practitioner partnership in clinical training: a critical evaluation. *Learning in Health and Social Care, (8)*1, 13-21.

Gale, N. (2011). From body-talk to body-stories: body work in complementary and alternative medicine, *Sociology of health and illness*, *33*(2): 237–251.

Geertz, C. (1973). *The interpretation of cultures.* London: Fontana.

Gellner, E. (1979). *Spectacles and predicaments*. Cambridge: Cambridge University Press.

Giddens, A. (2006). *Sociology*. Cambridge: Polity Press.

Giles, J. (2007). Degrees in homeopathy slated as unscientific. *Nature, 446*(2), 352-353.

Gilgun, J. (2005). The four cornerstones of evidence-based practice in social work. *Research in Social work Practice, 15*(1), 52-61.

Gobo, G. (2011). Ethnography. In D. Silverman (Ed.), *Qualitative research* (pp. 15-34), London: Sage.

Goldacre, B. (2007, November 16). *A kind of magic? The Guardian Online.* Retrieved November 11, 2010, from http://www.guardian.co.uk/science/2007/nov/16/sciencenews.g2

Goldstein, M. (1999). *Alternative healthcare: medicine, miracle, or mirage?* Philadelphia: temple University Press.

Goldstein, M. (2003). Reasons for using CAM. In M. Kelner, & B. Wellman (Eds.), *Complementary and Alternative Medicine: Challenge and Change* (pp.27-38). London: Routledge.

Hammersley, M., & Atkinson, P. (1995). Ethnography: principles in practice. London: Tavistock.

Hardey, M. (1998). *The social context of health.* Buckingham: Open University Press.

Hatton, K. (2008). *New directions in social work practice*. Southernhay: Learning Matters Ltd.

Hay, L. (1988). *You can heal your life.* Eden Grove Editions.

Hasegawa, H., Reilly, D., Mercer, S., & Bikker, A. (2005). Holism in primary care: The views of Scotland's general practitioners. *Primary Health Care Research and Development, 6*(4), 320–328.

Health and Care Professions Council. (2012). *Standards of Proficiency: Social Workers in England*. Retrieved on July 12, 2012, from http://www.hpc-uk.org/assets/documents/10003B08Standardsofproficiency-SocialworkersinEngland.pdf

Health Professions Council. (2005). *Standards of Education and Training.* Retrieved July 12, 2012, from http://www.hpc-uk.org/assets/documents/10000BCF46345Educ-Train-SOPA5_v2.pdf

Health Professions Council. (n.d.). *About us.* Retrieved February 12, 2012, from http://www.hpc-uk.org/aboutus/

Heller, T., Lee-Treweek, G., Katz, J., Stone, J., & Spurr, S. (2005). *Perspectives on complementary and alternative medicine*. Abingdon: Routledge.

Hensher, P. (2010, February 22). Homeopathy is a waste of NHS money. *The Independent.* Retrieved November 10, 2010, from http://www.independent.co.uk/opinion/commentators/philip-hensher/philip-hensher-homeopathy--is-a-waste-of-nhs-money-1906514.html

Higher Education Statistics Agency. (2011). *Students and qualifiers data tables.* Retrieved January 4, 2012, from http://www.hesa.ac.uk/index.php/content/view/1973/239/

Hill, F. (2003). Towards a new model for health promotion? An analysis of complementary and alternative medicine and models of health promotion. *Health Education Journal, 62*(4), 369-380.

Hirschkorn, K. (2006). Exclusive versus everyday forms of professional knowledge: Legitimacy claims in conventional and alternative medicine. *Sociology of Health and Illness*, *28*(5), 533-557.

Hoffmann, E. (2007). Open-ended interviews, power, and emotional labour. *Journal of Contemporary Ethnography, 36*(3), 318-346.

Hollenberg, D. (2006). Unchartered ground: Patterns of professional interaction among complementary/alternative and biomedical practitioners in integrative health care setting. *Social Science and Medicine, 62*(3), 731-744.

Holstein, J., & Gubrium, J. (1997). Active Interviewing. In D. Silverman (Ed.), *Qualitative research: Theory, method and practice* (pp. 113-129). London: Sage.

Homeopathy Accreditation Board. (2007). *Accreditation handbook.* Homeopathy Accreditation Board.

Hookway, N. (2008). 'Entering the blogosphere': some strategies for using blogs in social research, *Qualitative Research, 8*(1), 91-113.

Horner, N. (2003). *What is Social Work? Context and Perspectives*. Exeter: Learning Matters.

House of Lords Science & Technology Select Committee. (2000). *Sixth report: Complementary and alternative medicine.* [Electronic version]

House of Commons Science & Technology Committee. (2010). *Fourth report, evidence check 2: Homeopathy.* [Electronic version].

Hunt, K., Coelho, H., Wilder, B., Perry, R., Hung, S., Terry, R., & Ernst, E. (2010). Complementary and alternative medicine use in England: Results from a national survey. *International Journal of Clinical Practice, 64*(11), 1496-1502.

Hunt, K. (2009). The regulation of CAM practice in the UK: Complementary and it achieve its aim in safeguarding the public? *Focus on Alternative and Complementary Medicine, 14*(3), 167-170.

Illich, I. (1995). *Limits to medicine. Medical nemesis: the exploration of health.* London: Maryon Boyars (Original work published in 1976).

Isbell, B. (2004) Finding the right complementary therapies course, *Complementary Therapies in Nursing and Midwifery*, 10(2) 92-96

Jackson, S., & Scambler, G. (2007). Perceptions of evidence-based medicine: traditional acupuncturists in the UK and resistance to biomedical models of evaluation. *Sociology of Health & Illness, 29*(3), 412-429.

Jacobs, J. & Moskowitz, R. (2001). Homeopathy. In M. Micozzi (Ed.), *Fundamentals of complementary and alternative medicine* (pp. 87-99). Philadelphia: Churchill Livingstone.

Jamous, H., & Peloille, B. (1970). Changes in the French university-hospital system. In Jackson, J.A. (Ed.), *Professions and Professionalization.* Cambridge: Cambridge University Press.

Johnson, T. (1982). The state and the professions: Peculiarities of the British. In A. Giddens, & G. Mackenzie (Eds.), *Social class and the division of labour*, (pp. 186-208). Cambridge: Cambridge University Press

Jonas, W., & Levin, J. (1999). Introduction: Models of medicine and healing. In W. Jonas, & J. Levin (Eds.), *Essentials of complementary and alternative medicine* (pp. 1-15). London: Lippincott Williams and Wilkins.

Jonas, W., Kaptchuk, T & Linde, K. (2003). A critical review of homeopathy. *Annals of Internal Medicine, 38*(5), 393-400.

Jorgensen, D. (1989). *Participant observation: A methodology of human studies*. London: Sage.

Karban, K., & Smith, S. (2006). Developing critical reflection within an interprofessional learning programme [Conference paper]. Retrieved 20 July, 2012, from http://www.leeds.ac.uk/medicine/meu/lifelong06/

Kelner, M., & Wellman, B. (2003). *Complementary and alternative medicine: Challenge and change*. London: Routledge.

Kelner, M., Wellman, B., Boon, H., & Welsh, S. (2004). Responses of established healthcare to the professionalization of complementary and alternative medicine in Ontario. *Social Science & Medicine, 59*(5), 915-930.

Kelner, M., Wellman, B., Welsh, S., & Boon, H. (2006). How far can complementary and alternative medicine go? The case of chiropractic and homeopathy. *Social Science & Medicine, 63*(10), 2617-2627

Kerr, D., Walsh, D., & Baxter, G. (2001). A study of the use of acupuncture in physiotherapy. *Complementary Therapies in Medicine, 9*(1), 21-27.

Keshet, Y. (2009). The untenable boundaries of biomedical knowledge: Epistemologies and rhetoric strategies in the debate over evaluating complementary and alternative medicine. *Health, 13*(2), 131-155.

Keshet, Y. (2011). Energy medicine and hybrid knowledge construction: The formation of new cultural-epistemological rules of discourse. *Cultural Sociology, 5*(4), 501-518.

Kirschmann, A. (2003). *Vital force: women in American homeopathy.* New Brunswick: Rutgers University press.

Kohlbacher, F. (2006). The use of qualitative content analysis in case study research. *FQS Forum, Qualitative Social Research Sozialforschung*, *7*(1).

Kuhn, T. (1972). Scientific paradigms. In B. Barnes (ed.), *Sociology of science* (pp. 86-93). Harmondsworth: Penguin.

Lange, A. (2005). Homeopathy. In J. Pizzorno, & M. Murray (Eds.), *Textbook of natural medicine* (pp. 387-399). St. Louise: Churchill Livingstone.

Larson, M.S. (1980). Proletarianization and educated labour. *Theory and Society, 9*(1), 131-175

Lawrence, C., & Weisz, G. (1998).*Greater than the parts: holism in biomedicine, 1920-1950*. Oxford: Oxford University Press.

Lee-Treweek, G. (2005). Regulation, professionalization and education: change and diversity. In G. Lee-Treweek, T. Heller, S. Spurr, H. MacQueen, & J. Katz (Eds.), *Perspectives on Complementary and Alternative Medicine: A Reader* (pp. 211-213). Abingdon: Routledge.

Legard, R., Keegan, J., & Ward, K. (2003). In-depth Interviews. In J. Ritchie, & J. Lewith (Eds.). *Qualitative research practice* (pp. 138-169). London: Sage.

Lewith, G. (1998). Misconceptions about research in complementary medicine. In A. Vickers (Ed.), *Examining complementary medicine* (pp. 170-176). Cheltenham: Stanley Thornes.

Lewith, G. (2004). Can practitioners be researchers? *Complementary Therapies in Medicine,* 12(1), 2-5.

Lowenberg, J., & Davis, F. (1994). Beyond medicalisation-demedicalisation: The case of holistic health. *Sociology of Health and Illness, 16*(5), 579-599.

Lupton, D. (2006). *Medicine as culture*. London: Sage.

Macdonald, K. (1995). *The sociology of the professions.* London: Sage.

Maciocia, G. (1989). *The foundation of Chinese medicine.* New York: Churchill Livingstone.

MacLennan, A., Wilson, D., & Taylor, A. (2002). The escalating cost and prevalence of alternative medicine. *Preventive Medicine*, *35*(2), 166-173.

Margetts, B. (2004). An overview of public health nutrition. In M. Gibney, B. Margetts, J. Kearney, & L. Arab (Eds.), *Public Health Nutrition* (pp. 1-25). Oxford: Blackwell publishing.

Markham, A. (2004). Internet communication as a tool for qualitative research. In D. Silverman (Ed.), *Qualitative research: Theory, method and practice*, (pp. 95-124) London: Sage.

Markham, A. (2011). Internet research. In D. Silverman (Ed.), *Qualitative research: issues of theory, method and practice, 3rd Ed.,* (pp. 111-128).

Mason, J. (1996). *Qualitative researching.* London: Sage.

Mayring, P. (2000). Qualitative content analysis. *FQS Forum, Qualitative Social Research Sozialforschung*, *1*(2).

McEvoy, L., & Duffy, A. (2008). Holistic practice – A concept analysis. *Nurse Education in Practice, 8*(6), 412-419.

Merriam, S., Johnson-Bailey, J., Lee, M., Kee, Y., Youngwha, K., Ntseane, G., & Muhamad, M. (2001). Power and positionality: Negotiating insider/outsider status within and across cultures. *International Journal of Lifelong Education, 20*(5), 405-416.

Micozzi, M. (2006). Characteristics of complementary and integrative medicine. In M. Mocozzi (Ed.), *Fundamentals of complementary and integrative medicine* (pp. 3-8). St. Louise: Saunders Elsevier.

Millerson, G.L. (1964). *The qualifying association*. London: Routledge & Kegan Paul.

Mitchell, A., & Cormack, M. (2005). What is distinctive about complementary medicine? In G. Lee-Treweek, T. Heller, S. Spurr, H. MacQueen, & J. Katz (Eds.), *Perspectives on complementary and alternative medicine* (pp. 100-105). London: Routledge.

Montgomery, S. L. (1993). Illness and image in holistic discourse. *Cultural Critique, 25*(1993), 65-89

Morell, P. (1998). *Aristocratic social networks and homeopathy in Britain*. Retrieved on 10 December 2011 from http://www.homeoint.org/morrell/articles/pm_arist.htm

Morse, J.M., Barrett, M., Mayan, M., Olson, K., & Spiers, J. (2002). Verification Strategies for Establishing Reliability and Validity in Qualitative Research. *International Journal of Qualitative Methods, 1*(2) Spring 2002. Retrieved on 21 July, 2012 from http://www.ualberta.ca/~iiqm/backissues/1_2Final/pdf/morseetal.pdf

Murray, M., & Kujundzic, N. (2005). *Critical reflection: A textbook for critical thinking*. Quebec: McGill-Queen's University Press.

Naidoo, J., & Wills, J. (2000). *Health Promotion: Foundations for Practice. (2nd ed.).* London: Bailliere Tindall.

National Center for Complementary and Alternative Medicine. (2008). *The use of complementary and alternative medicine in the United States.* Retrieved July 10, 2010, from http://nccam.nih.gov/news/camstats/2007/camsurvey_fs1.htm

Nettleton, S. (1995). *The sociology of health and illness.* Cambridge: Polity Press.

Nicholls, P. (2005). Homeopathy, hospital and high society. In G. Lee-Treweek, T. Heller, S. Spurr, H. MacQueen, & J. Katz (Eds.), *Perspectives on complementary and alternative medicine* (pp. 202-221). London: Routledge.

Nicholls, P., Lee-Treweek, G., & Heller, T. (2005). Homeopathy: principles, practice and controversies. In: G. Lee-Treweek, T. Heller, H. MacQueen, J. Stone, & S. Spurr (Eds.), *Complementary and alternative medicine: Structures and safeguards* (pp. 101-126). London: Routledge.

Nicholls, D., & Cheek, J. (2006). Physiotherapy and the shadow of prostitution: The Society of Trained Masseuses and the massage scandals of 1894. *Social Science and Medicine, 62* (2006), 2336–2348.

Ock, S., Choi, Y., Cha, Y., Lee, J., Chun, M., Hun, C., Lee, S., & Lee, S. (2009). The use of complementary and alternative medicine in a general population in South Korea: Results from a national survey in 2006. *Journal of Korean Medical Science, 24*(1),1-6.

Ong, C., Bodeker, G., Grundy, C., Burford, G., & Shein, K. (2005). *WHO global atlas of traditional, complementary and alternative medicine.* Kobe: World Health Organisation.

Ong, C., & Banks, B. (2003). *Complementary and Alternative Medicine: the consumer perspective.* London: The Prince of Wales's Foundation for Integrated Health.

Orme, J., Macintyre, G., Green, P., Cavanagh, K., Crisp, R., Hussein, S., Manthorpe, J., Moriarty, J., Sharpe, E., & Stevens, M. (2009). What (a) difference a degree makes: The evaluation of the new social work degree in England. *British Journal of Social Work*, *39*(1), 161-178.

Orthomolecular medicine online. (n.d.). *Orthomolecular medicine.* Retrieved on July 3, 2011, from http://www.orthomed.org/index.html

Parahoo, K. (2006). *Nursing research: principles, process and issues.* Basingstoke: Palgrave Macmillan.

Parkin, F. (1974). *Strategies of social closure in class structure*. London: Tavistock.

Parsons, T. (1939). The Professions and Social Structure, *Social Forces*, *17*(4), 457-467.

Parsons, T. (1991). *The social system*. London: Routledge (original work published in 1951).

Paterson, C., & Britten, N. (2008). The patient's experience of holistic care: insights from acupuncture research. *Chronic Illness, 4*(4), 264-277.

Peters, D. (1998). Is complementary medicine holistic? In A. Vickers (Ed.), *Examining complementary medicine* (pp. 140-146). Cheltenham: Nelson Thornes Ltd.

Pietroni, P. (1997). Is complementary medicine holistic? *Complementary Therapies in Nursing and Midwifery, 3*(1) 9-11.

Polit, D., & Beck, C. (2010). Generalization in quantitative and qualitative research: myths and strategies. *International Journal of Nursing Studies*, *47*(11), 1451-1458.

Pope, C., & Mays, N. (1995). Researching the parts other methods cannot reach: An introduction to qualitative methods in health and health services research. *British Medical Journal, 311*(6996), 42-45.

Porter, R. (2002). *Blood and guts.* London: W.W. Norton & company.

Procter, S., & Allan, T. (2006). Sampling. In K. Gerrish, & A. Lacey (Eds.), *The research process in nursing* (5th ed., pp. 173-191). Oxford: Blackwell.

Ramey, D., & Buell, P. (2004). A true history of acupuncture. *Focus Altern Complement Therapy, 2004*(9), 269-73.

Ritchie, J. (2003). The Applications of Qualitative Research methods to Social Research. In J. Ritchie, & J. Lewith, (Eds.), *Qualitative research practice (*pp. 24-46). London: Sage.

Robbins, T. (2010, July 6).Homeopathy and Dr James Le Fanu: if this is a witch hunt, help me find my torch. *The Telegraph Online.* Retrieved October 11, 2010, from *http://www.telegraph.co.uk/science/7874940/Homeopathy-and-Dr-James-Le-Fanu-if-this-is-a-witch-hunt-help-me-find-my-torch.html*

Rosaldo, R. (1993). *Culture and truth: The remarking of social analysis*. Melksham: Redwood Press Limited.

Rosenberg, C. (1998). Holism in twentieth-century medicine. In C. Lawrence, & G. Weisz (Eds.), *Greater than the parts: holism in biomedicine, 1920-1950* (pp. 335-357). Oxford: Oxford University Press.

Royal College of Nursing. (2003). *Complementary therapies in nursing, midwifery and health visiting practice: RCN guidance on integrating complementary therapies into clinical care*. London: RCN.

Ruch, G. (2002). From triangle to spiral: Reflective practice in social work education, practice and research, *Social Work Education: The International Journal, 21*(2), 199-216.

Sackett, .L, Rosenberg, W., Gray, J., Haynes, R., & Richardson, W. (1996). Evidence based medicine: what it is and what it isn't. *British Medical Journal, 12(*7023), 71-72.

Saks, M. (1995). The changing response of the medical profession to alternative medicine in Britain: a case of altruism or self-interest? In T. Johnson, G.

Larkin, & M. Saks (Eds.), Health professions and the state in Europe (pp.103-115). London: Routledge.

Saks, M. (1997). Alternative therapies: Are they holistic? *Complementary Therapies in Nursing and Midwifery, 3*(1), 4-8.

Saks, M. (1998). Medicine and complementary medicine: challenge and change. In G. Scambler, & P. Higgs (Eds.), *Modernity, medicine and health: medical* sociology towards 2000 (pp.198-215). London: Routledge.

Saks, M. (1999). The wheel turns? Professionalisation and alternative medicine in Britain. *Journal of Interprofessional Care, 13*(2), 129-138.

Saks, M. (2001). Alternative medicine and the health care division of labour: present trends and future prospects. *Current Sociology, 49*(3), 119-134.

Saks, M. (2003a). Bringing together the orthodox and alternative in healthcare. *Complementary Therapies in Medicine, 11*(3), 142-145.

Saks, M. (2003b). Professionalization, politics and CAM. In M. Kelner, & B. Wellman (Eds.), *Complementary and alternative medicine: Challenge and change* (pp. 223-238). London: Routledge

Saks, M. (2005a). Regulating complementary and alternative medicine: The case of acupuncture. In T. Heller, G. Lee-Treweek, J. Katz, J. Stone, & S. Spurr (Eds.), *Perspectives on complementary and alternative medicine: A reader* (pp. 252-259). London: Routledge.

Saks, M. (2005b). Political and historical perspectives. In T. Heller, G. Lee-Treweek, J. Katz, J. Stone, & S. Spurr (Eds.), *Perspectives on complementary and alternative medicine* (pp.59-82). London: Routledge.

Saks, M., & Lee-Treweek, G. (2005). Political power and professionalization. In G. Lee-Treweek, T. Heller, H. MacQueen , J. Stone, & S. Spurr (Eds.), *Complementary and alternative medicine: Structures and safeguards* (pp. 75-100). London: Routledge.

Salkeld, E. (2005). Holistic physicians' clinical discourse on risk: An ethnographic study. *Medical Anthropology*, *24*(4), 325-347.

Sample, I. (2009, June 1). British scientists ask WHO to condemn homeopathy for diseases such as HIV. *The Guardian Online.* Retrieved June 19, 2009, from http://www.guardian.co.uk/science/2009/jun/01/world-health-organisation-homeopathy-hiv

Sample, I. (2010, October 27). NHS funding for homeopathy risks misleading patients, says chief scientist. *The Guardian Online.* Retrieved November 25, 2010, from http://www.guardian.co.uk/science/2010/oct/27/nhs-funding-homeopathy-chief-scientist

Savage-Smith, E. (1997). Europe and Islam. In I. Loudon (Ed,), *Western medicine: An illustrated history* (pp. 40-53). Oxford: Oxford University Press.

Schneirov, M., & Geczik, J. (2002). Alternative health and the challenges of institutionalization. *Health, 6*(2), 201-220.

Schön, D. (1983). The reflective practitioner: how professionals think in action. London: Maurice Temple Smith.

Scott, A. (1998). Homeopathy as a feminist form of medicine. *Sociology of Health and Illness, 20*(2), 191-214.

Scott, A. (1999). Paradoxes of holism: Some problems in developing an anti-oppressive medical practice. *Health, 3*(2), 131-149.

Sharma, U. (1996). Building a professional community: Collective culture in a group of none medically qualified homeopaths in Britain. In T. Heller, G. Lee-Treweek, J. Katz, J. Stone, & S. Spurr (Eds.), *Perspectives on complementary and alternative medicine: A reader* (pp. 260-267). London: Routledge.

Sharma, U. (1998). Reasonable consensus, self-criticism and the grounds of debate: A case from homeopathy. In A. Vickers (Ed.), *Examining complementary medicine* (pp. 159-169). Cheltenham: Nelson Thornes Ltd.

Sharma, U. (2003). Medical pluralism and the future of CAM. In M. Kelner, & B. Wellman (Eds.), *Complementary and alternative medicine: Challenge and change* (pp. 211-222). London: Routledge.

Sharma, U. (2005). Building a professional community: Collective culture in a group of non-medically qualifies homeopaths in Britain. In T. Heller, G. Lee-Treweek, J. Katz, J. Stone, & S. Spurr (Eds.), *Perspectives on complementary and alternative medicine: A reader* (pp. 260-268). London: Routledge.

Sheldon, B. (2001). The validity of evidence-based practice in social work: A reply to Stephen Webb. *British Journal of Social Work, 31*(5), 801-809

Shuval, J., Mizrachi, N., & Smetannikov, E. (2002). Entering the well-guarded fortress: Alternative practitioners in hospital settings. *Social Science & Medicine, 55*(2002), 1745-1755.

Silverman, D. (2011). *Interpreting qualitative data*. London: Sage.

Skills for Health. (2009). National Occupational Standards (NOS) for homeopathy. Retrieved on 10 February 2012 from the SoH website http://www.homeopathy-soh.org/attachments/2012/01/nos-sep2011.pdf

Society of Homeopaths. (2006). *Educational policy.* Society of Homoeopaths.

Society of Homeopaths. (2010). *Clinical educational guidelines*. Society of Homeopaths.

Society of Homeopaths. (2011a). *Our members.* Retrieved August 1, 2011, from http://www.homeopathy-soh.org/about-the-society/who-we-are/our-members/

Society of Homeopaths. (2011b). *What is homeopathy?* Retrieved October 5, 2011, from http://www.homeopathy-soh.org/about-homeopathy/what-is-homeopathy/

Society of Homeopaths. (n.d.). *Recognised list.* Retrieved November 10, 2010, from http://www.homeopathy-soh.org/becoming-a-homeopath/course-recognition/recognised-list.aspx

Society of Homeopaths Education Department. (2009). *Aiming for excellence – homeopathy and higher education.* Society of Homeopaths.

Stone, J., & Katz, J. (2005). Can complementary and alternative medicine be classified? In T. Heller, G. Lee-Treweek, J. Katz, J. Stone, & S. Spurr (Eds.), *Perspectives on complementary and alternative medicine* (pp. 29-52). London: Routledge.

Swayne, J. (1998). Homeopathic therapeutics: Many dimensions – or meaningless diversity? In S. Vickers (Ed.), *Examining complementary medicine* (pp. 64-73). Cheltenham: Stanley Thornes.

The Daily Mail Online. (2008, April 23). Shamed: Universities offering 'bogus' degrees in alternative medicine. *The Daily Mail Online*. Retrieved April 21, 2011, from http://www.dailymail.co.uk/news/article-1016640/Shamed-Universities-offering-bogus-degrees-alternative-medicine.html

The Prince of Wales's Foundation for Integrated Health. (2008). *Complementary healthcare: a guide.* Retrieved May 5, 2010, from http://www.fih.org.uk/information_library/complementary_healthcare_a_guide/index.html

The Prince's Foundation for Integrated Health. (2009). *HE Accredited Courses in Complementary Healthcare 2009*. Retrieved September 21, 2009, from http://www.fih.org.uk/information_library/publications/health_guidelines/he_accredited.html

The Sun Online. (22 January 2009). Why I am so sick of alternative therapy. *The Sun Online.* Retrieved November 25, 2010, from http://www.thesun.co.uk/sol/homepage/woman/health/health/drkeithhopcroft/2157641/Why-Im-so-sick-of-alternative-therapy.html

Thomas, K., Nicholl, J., & Coleman, P. (2001). Use and expenditure on complementary medicine in England—a population-based survey. *Complementary Therapies in Medicine, 9*(1), 1–11.

Thomas, K., Coleman P., & Nicholl, J. (2003). Trends in access to complementary or alternative medicines via primary care in England: 1995–2001. Results from a follow-up national survey. *Family Practice, 20*(5), 575-577.

Thomas K., & Coleman P. (2004). Use of complementary or alternative medicine in a general population in Great Britain. Results from the National Omnibus Survey. *Journal of Public Health,* 26(2), 152-157.

Thomas, P. (2001). Homeopathy in the USA. *British Homeopathic Journal, 90*(2), 99-103.

Timmermans, S., & Mauck, A. (2005). The promises and pitfalls of evidence-based medicine. *Health Affairs, 24*(1), 18-28.

Timmons, S. (2010). Professionalization and its discontent. *Health, 15*(4), 337-352.

Tonkiss, F. (2004). Analysing text and speech: Content and discourse analysis. In C. Seale (Ed.), *Researching Society and Culture* (pp. 367-382). London: Sage.

Tovey, P., Easthope, G., & Adams, J. (2004). Introduction. In P. Tovey, G. Easthope, & J. Adams (Eds.), *The Mainstreaming of complementary and alternative medicine*. London: Routledge.

Turner, B. (1995). *Medical power and social knowledge.* London: Sage.

Turner, B. (2004). Forward: The end(s) of scientific medicine? In P. Tovey, G. Easthope, & J. Adams (Eds.) *The mainstreaming of complementary and alternative medicine*. (pp. xiii-xxx). London: Routledge.

Ulett, G., Han, J., & Han, S. (1998). Traditional and evidence-based acupuncture: History, mechanisms and present status. *Southern Medical Journal, 91*(12), 1115-1120.

VanderPloeg, K., & Yi, X. (2009). Acupuncture in modern society. *Journal of Acupuncture and Meridian Studies, 2*(1), 26-33.

Vickers, A. (1998). Criticism, Scepticism and Complementary Medicine. In A. Vickers,(Ed.), *Examining complementary medicine* (pp. 1-16). Cheltenham: Stanley Thornes.

Walsh, D. (2004). Doing Ethnography. In C. Seal (Ed.), *Researching society and culture* (pp. 225-237). London: Sage.

Webb, S. (2001). Some considerations on the validity of evidence-based practice in social work. *British Journal of Social Work, 31*(1), 57-79.

Welsh, S., Kelner, M., Wellman, B., & Boon, H. (2004). Moving forward? Complementary and alternative practitioners seeking self regulation. *Sociology of Health and Illness, 26*(2), 216–241.

Welsh, I., & Lyons, C. (2001). Evidence-based care and the case for intuition and tacit knowledge in clinical assessment and decision making in mental health nursing practice: an empirical contribution to the debate. *Journal of Psychiatric and Mental Health Nursing, 8*(4), 299-305.

Wiese, M., Oster, C., & Pincombe, J. (2010). Understanding the emerging relationship between complementary medicine and mainstream health care: A review of the literature. *Health, 14*(3), 326-342.

White, A. (2009). Western medical acupuncture: A definition. *Acupuncture in Medicine, 27*(1), 33-35.

White, A., & Ernst, E. (2004). A brief history of acupuncture. *Rheumatology, 43*(5), 662-663.

Wiliams, L., Jack, P., & Russo, H. (2004). Regulating complementary medicine: implications for the nursing profession. *Nursing Times Research. 9*(2), 88-100.

Williams, L., Stone, J., & Lee-Treweek, G. (2005). Education and training in CAM. In G. Lee-Treweek, T. Heller ,H. MacQueen, J. Stone, & S. Spurr (Eds.). *Complementary and alternative medicine: Structures and safeguards* (pp. 27-52). Abingdon: Routledge.

Witz, A. (1990). Patriarchy and professions: The gendered politics of occupational closure. *Sociology, 24*(4), 675-690.

Witz, A. (1992). *Professions and patriarchy*. London: Routledge.

World Health Organisation (2002). *WHO Traditional Medicine Strategy 2002-2005*. Geneva, WHO. Retrieved July 1, 2012, from http://apps.who.int/medicinedocs/pdf/s2297e/s2297e.pdf

Wyatt, A. (2003). Paramedic Practice – Knowledge Invested in Action. *Journal of Emergency Primary Health Care, 1*(3-4), Article No. 990057. [electronic copy].

Yates, S.J. (2004). *Doing social science research.* London: Sage.

Zola, I.K. (1972). Medicine as an institution of social control. *Sociological Review. 20*(4), 487-504.

Appendices

1. The study information sheet
2. Informed consent form
3. A letter confirming ethical approval granted by NHS National Research Ethics Service (NRES)

Dr Jeannette Bartholomew BSc PhD PGCE ILTM
Head of School

School of Health Sciences and Social Work
University of Portsmouth
James Watson Hall (West)
2 King Richard 1st Road
Portsmouth PO1 2FR
United Kingdom

T: +44 (0)23 9284 4440
F: +44 (0)23 9284 4402

Information sheet:

Holism in acupuncture and homeopathy practice: An in-depth, qualitative study

Dear practitioner,

My name is Assaf Givati and I am a lecturer at the School of Health Sciences & Social Work, University of Portsmouth. Currently I am working on a PhD research which considers aspects of acupuncture and homeopathy practice in the UK. I would very much like to invite you to take part in the study and I would appreciate the opportunity listen to your experiences and views in relation to your practice.

The research objective is to describe the values and meanings attached to holism in the context of acupuncture and homeopathy. This study seeks to contribute to a description of actual CAM practice and its presentation in training, education and research.

Taking part in the study is via an interview. It is entirely voluntary. If you are happy to participate, you are still free to withdraw at any time and without giving any reason for it. The interview will include several broad questions regarding your practice and will last for as long as you need to present your views and describe your experiences, typically about an hour. The interview can take place in a location that is comfortable for you: at your clinic, your house, or at the University of Portsmouth.

Confidentiality: Anonymity of participants in the interviews is maintained both during the study and in future publications. The interview will be tape-recorded and transcribed. Tapes will be kept locked at my university desk or on my private PC and will be destroyed once the research is completed.

Ethical approval: the study has NHS ethical approval (NREC).

If you agree to participate please complete the reply slip in the attached letter and return it to me via e-mail or regular mail (using the pre-paid envelope attached) to my address below.

If you wish to receive a summary of the findings or a copy of the interview-transcription please let me know and I will be happy to provide it to you.

Thank you very much for your participation,

Assaf Givati

My contact details:

School of Health Sciences & Social Work

University of Portsmouth

James Watson Hall West

2 King Richard 1st Road

Portsmouth PO1 2FR

Telephone: 023 9284 4418

Email: assaf.givati@port.ac.uk

Address of research academic supervisor (complaints):

Dr. Ann Dewey

School of Health Sciences & Social Work

University of Portsmouth

James Watson Hall West

2 King Richard 1st Road

Portsmouth PO1 2FR

Telephone: 023 9284 4426

Email: ann.dewey@port.ac.uk

Participant Identification Number:
(Office use only)

CONSENT FORM

'Holism' in homeopathy and acupuncture practice: An in-depth, qualitative study

Please Initial Box

1) I confirm that I have read the email / letter describing the study……..

2) I give my permission for the interview to be audio-recorded so the discussion can be analysed by members of the research team…….

3) I understand that the tape-recordings will be destroyed after they have been analysed in accordance with the Data Protection Act……

4) I understand that my participation is voluntary and that I will be free to leave the interview at any time, without giving any reason…….

5) I understand that my participation is voluntary and that I will be free to leave the study at any time, without giving any reason…….

---------- ---------- ----------

Your name (printed) **Date** **Signature**

Do you want to check the interpretation of this interview before it is written up for publication?

Yes No

NHS
National Research Ethics Service
NRES Committee South Central - Southampton A
Level 3, Block B
Whitefriars
Lewins Mead
Bristol
BS1 2NT

Tel: 0117 3421384
Fax: 0117 3420445

19 August 2011

Mr Assaf Givati
Senior lecturer
University of Portsmouth, School of Health Sciences & Social Work
James Watson Hall West
2 King Richard 1st Road
Portsmouth
PO1 2FR

Dear Mr Givati

Study title:	**'Holism' in homeopathy and acupuncture practice in the UK: A mixed-method, descriptive study, stage 1**
REC reference:	**08/H0502/2**

This study was given a favourable ethical opinion by the Committee on 22 February 2008.

Research Ethics Committees are required to keep a favourable opinion under review in the light of progress reports and any developments in the study. You should submit a progress report for the study 12 months after the date on which the favourable opinion was given, and then annually thereafter. Our records indicate that a progress report is overdue. It would be appreciated if you could complete and submit the report by no later than one month from the date of this letter.

Guidance on progress reports and a copy of the standard NRES progress report form is available from the National Research Ethics Service website.

The NRES website also provides guidance on declaring the end of the study.

Failure to submit progress reports may lead to the REC reviewing its opinion on the study.

08/H0502/2:	**Please quote this number on all correspondence**

Yours sincerely

Ms Maxine Knight
Committee Co-ordinator

E-mail: scsha.swhreca@nhs.net