Strategies of complementary and alternative medicine practitioners to achieve occupational closure within healthcare in Portugal[1]

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Abstract: The aim of this paper is to analyse the main strategies of closure that have been enacted by CAM practitioners in order to achieve occupational control over work domains in the Portuguese healthcare market since the late 1990s. Abbott's jurisdictional vacancy theory, Neo-Weberian occupational closure theory, and Light's countervailing power concept, are proposed as a framework for analysis. Acupuncture and homeopathy will be presented as case studies. Data are derived from in-depth interviews with 10 traditional acupuncturists and 10 traditional homeopaths. The data analysis suggested that expressing 'countervailing values', professionalising and forming alliances with the medical profession have been the main strategies used by CAM practitioners in an attempt to achieve inclusion and hence closure. It will be argued that a further outcome of these strategies is the promotion of CAM treatments and solutions to human problems, sometimes as complementary, other times as alternative, to medical solutions. The promotion of CAM can thus impact on the medicalisation process of certain conditions, and its sociological analysis can contribute to take the medicalisation debate towards unexplored theoretical grounds.

Keywords: Complementary and alternative medicine, medical profession, strategies of closure, promotion of CAM, Portugal

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Introduction

The research reported here explores the hitherto neglected relationship between complementary and alternative medicine (CAM) and the medical profession in Portugal. While the 'revival' of CAM (Cant and Sharma 1999) and the subsequent claims made by CAM practitioners for legitimacy, have been the focus of sociological research on the changing relationship between CAM and the medical profession in countries other than Portugal, these issues have yet to be explored in the Portuguese context.

This paper specifically concentrates on the recent strategies used by CAM practitioners in order to gain legitimacy within Portuguese healthcare. These strategies will be examined through case studies on acupuncture and homeopathy. In Portugal, acupuncture and homeopathy are two out of seven CAM therapies that have been regulated by the State. The statutory regulation of these seven (initially six) CAM therapies however has lasted for more than 10 years and has been a hectic process, due to an interesting interplay between these CAM therapies, the State and the medical profession. Very recently, on the 24th July 2013, the Portuguese parliament passed a new Act (71/2013) which approved seven CAM therapies: acupuncture, homeopathy, osteopathy, chiropractic, naturopathy, fitotherapy and traditional Chinese medicine[1]. Therefore, recent changes in Portuguese legislation with respect to CAM have placed Portugal amongst those countries with governmental support for the increasing convergence of CAM and orthodox medicine. The UK, the Netherlands, Germany, Canada, the USA and Australia are other examples of this trend. It thus seems that Portugal has undergone a similar process to other countries, which makes the country an interesting case for analysis.

Theoretical background

Research on the changing relationship between CAM and the medical profession worldwide has shown that since the late 1960s CAM practitioners have emerged as an occupational group with collective interests which have been in tension with those of the medical profession (Cant and Sharma 1999). Fundamentally, CAM practitioners started promoting alternative conceptualisations of healing at a time when biomedicine's tenets began to be questioned (Saks 1995). Previous studies (Jackson and Scambler 2007; Bakx 1991) have suggested that holism, prevention and clinical pragmatism have been significant 'knowledge

claims' used by CAM practitioners in response to biomedical reductionism in healing, the overemphasis on curative medicine and the ideology of scientific evidence respectively. Furthermore, these claims have been seen as being made by CAM practitioners to compensate for biomedical imbalances over time such as *iatrogenesis* (Illich 1977), medicalisation, overmedication and the dehumanisation of healthcare services.

One could conceptualise these claims as 'legitimacy values', which define the character of CAM and help it to acquire jurisdiction (Abbott 1988). CAM's legitimacy values, however, have reflected the recent countervailing power (Light 2010) of CAM in offsetting some aspects of the biomedical world view. The expression of countervailing values by CAM practitioners may have helped define specific work domains and emphasised the need to fill 'jurisdictional vacancies', some of which have been left open by the medical profession (Abbott 1988). The emphasis on countervailing values can thus be seen as a main conceptual mechanism to help spread CAM treatments and solutions to human problems.

Simultaneously, a closure theory of professions is adopted here to show how strategies of closure employed by CAM practitioners can potentially challenge legitimised healthcare provision. Recent literature has shown that CAM practitioners have engaged in many Western countries in inclusionary strategies typical of professionalising groups. Professionalisation, or the process by which CAM practitioners have acquired control and autonomy over work in the market (Witz 1992), has been a main strategy of inclusion. Two main dimensions of this process can be identified: structural changes in CAM, i.e. in the way CAM therapies have organised and represented themselves; and changes in CAM's knowledge base, i.e. in the content of their work. The latter dimension has been noted by authors such as Cant (1996) and Saks (1995) in the British context. Cant's (1996) account of British homeopathy and chiropractic, for instance, has shown how these two therapies have altered their knowledge basis in order to ensure their survival within the system of professions, developed a relationship of trust with the lay public, and won respect from the medical profession. Cant (1996) showed how homeopathy and chiropractic's attempts to professionalise have been associated with the creation of professional associations and accredited training courses, which, in turn, have led to the development of scientific knowledge and to a 'tempering of knowledge claims'. Saks (1995), in his analysis of British

acupuncture, has shown how this therapy has redefined its knowledge base from a broad-ranging practice centred on traditional Eastern philosophies to a restrictive practice with a more limited use.

Although CAM therapies express countervailing values in relation to biomedicine, some have accommodated a biomedical model and have consequently become biomedicalised (McClean 2003). Cant (2009) illustrates how non-orthodox care in Britain has been increasingly shaped by biomedicine within the NHS with the former achieving the status of 'mainstream marginality', i.e. being integrated into healthcare but in biomedical terms. Recent research (Kelner et al. 2006) has shown that chiropractors and homeopaths have made major concessions to medical science as a strategy to gain legitimacy. By allying themselves with biomedical science and biomedical doctors, such CAM practitioners hope to achieve benefits such as higher symbolic status and public legitimacy, which will put them in a better position to promote CAM within healthcare.

These strategies have been the main ways for CAM practitioners to achieve occupational closure and therefore legitimacy within mainstream healthcare in Western countries other than Portugal. They have helped define the work domain of CAM within the marketplace. It is therefore of interest to establish the extent to which CAM practitioners have adopted these strategies in order to achieve occupational closure in Portugal since the late 1990s, when the first political actions in relation to CAM legislation started. This paper thus attempts to answer the following research question: what main strategies have CAM practitioners used to be included in mainstream healthcare in Portugal since the late 1990s?

Methods

An important reason for choosing acupuncture and homeopathy as cases for this research is that both are included in the list of six CAMs under statutory regulation in Portugal. Furthermore, these two therapies are worth comparing because they differ in status: acupuncture is an Eastern non-medication therapy with increasing significance as complementary to medical orthodoxy while homeopathy is a Western medication therapy which has not achieved complementary status in the same way as acupuncture and is generally still viewed as an alternative to the biomedical model.

This paper explores data obtained from interviews with rank-and-file traditional acupuncturists and traditional homeopaths and with members of the CAM elite (n=20). Rank-and-file traditional acupuncturists (n=7) and traditional homeopaths (n=5), i.e. non-medically trained practitioners who are not directly involved with CAM regulation, were selected by using the snowball technique; acupuncture (n=3) and homeopathic leaders (n=5), on the other hand, were selected purposively on the basis of their key role in the regulation process of CAM. An open-ended topic guide was used during the interviews and covered issues such as strategies to maintain/gain status/power within healthcare, CAM challenges to the medical profession and intra-professional relationships.

The research reported here acquired university ethics approval. Subsequently, an information sheet with details about the research was sent in advance to potential participants, along with a consent form, in order to obtain their written consent to participate and to use the information they provide for research purposes. Interview codes were used and references to places were omitted on purpose in order to protect the personal identity of the participants.

The individual interviews were conducted in different parts of Portugal by the author between June 2008 and April 2009 and took place in a variety of public and private spaces: consulting rooms in clinics, universities, cafes, public gardens and interviewees' homes. The average length of the interviews was two hours. All the interviews were taped using a MP3 recorder and later transferred to the computer program Transana 2.12, a computer assisted qualitative data analysis software system which assisted with the transcription of the digital audio files. The interview data were then transferred to the Atlas.ti5 to assist with their coding and storage.

The analysis of the interview data draws partially on a grounded theory approach, which, as its founders Glaser and Strauss (1968) state, is a strategy for discovering theory and built on a strong empirical base. We took into consideration specific aspects of this approach such as the 'constant comparative method', a continuous process which involves the separation and comparison of data through coding, labelling and memo-writing. This process led to the development of our conceptual framework.

The research reported here, is based on a small sample collected in one particular context. Therefore, generalisability is based on the plausibility of the analysis of the strategies of occupational closure identified.

We now turn to the investigation of the dominant strategies of inclusion enacted by CAM practitioners to achieve occupational closure in Portugal.

Strategies of inclusion employed by CAM practitioners

Acupuncture and homeopathy have enacted similar strategies of inclusion in Portugal; namely expressing countervailing values, professionalisation through credentialism and forming alliances with biomedical science. These strategies have been chosen over others because they are seen as in line with patients' current interests and with a new trend in national and international health policy: the move towards pluralism. We now turn to look at the first of these strategies in more detail.

Expressing Countervailing Values

In Portugal CAM practitioners have promoted 'legitimacy values' (Abbott 1988), to which they are committed and which have been ignored by biomedicine. These legitimacy values are of a countervailing nature as they compete with some of the values of modern medicine. All CAM's 'countervailing values' place significant emphasis on a patient-centred model of care. This section will now address them in more detail, focusing in turn on holism, prevention, alternative healing and clinical pragmatism.

Holism

Both the traditional acupuncturists and traditional homeopaths claimed that patients should be assessed holistically, often contrasting this to the reductionism of the biomedical approach to healing. One rank-and-file acupuncturist who had recently graduated in TCM and was providing consultations in a private clinic commented that:

> Perhaps being a traditional acupuncturist nowadays means being a doctor fifty years ago. [It] means knowing our patients very well, trying to understand the link between

> their lifestyle and their illness … their environment … all of this … because it's important and also I think that being a doctor at present just means treating diseases. (I2: TA)

It is apparent from this statement that being a 'traditional acupuncturist' is defined as the opposite of being a 'doctor' now. The respondent highlighted the social environment of patients not just the physiological aspects of the ill body. This move from an emphasis on symptoms to an emphasis on the patient as a whole person was a device used by most of the respondents. Interestingly, it was also a device used in the past by general practitioners (GPs) in Britain in their attempts to survive the early 19th century shift towards medical specialism (Armstrong 1979). By emphasising values expressed by biographical medicine, where the patient moves '… from [being] a passive receptacle of organic pathology to [being] the centre of the medical problematic' (Armstrong 1979:5), the GP could distinguish their general practice from other medical specialisms and secure their role within British medical practice. Now, in the 21st century, CAM practitioners in Portugal are the ones who have forged new patient-centred approaches to healing which seem to counterbalance some aspects of biomedical practice.

References to holistic health were accompanied frequently by an emphasis on restorative care and a rebalancing of health. As one homeopathic leader and a representative of a prominent homeopathic association, the *Portuguese Association of Homeopathy* (APH), pointed out:

> [Doctors should] treat first and then … should send [the patient to the homeopath] to restore what has been distorted. That's alright if [surgery] was needed but by doing this they [the doctors] have disturbed the patient's sense of equilibrium, you see. And this seems a paradox. They've disturbed the balance but they've restored it in some way. And so caring should be shifted then [from biomedicine] to natural medicine to assure the patient's well-being and respect. (I13: TH)

This traditional homeopath placed emphasis on biomedical imbalances such as *iatrogenesis* (Illich 1977). Such imbalances may provide an opportunity for CAM practitioners to encroach upon mainstream healthcare. For instance, one of the claims made by most of the respondents was the ability to restore patients' sense of balance following invasive

biomedical procedures and to deal with conditions arising from the adverse effects of certain biomedical measures such as surgery. So, one can denote here an attempt to promote CAM in the treatment of iatrogenic effects derived from the medicalisation of human problems.

Claims for holistic health often included an emphasis on humanised care. This is illustrated by the following statement from a rank-and-file traditional homeopath, who worked for a pharmaceutical company before fully committing to homeopathy and naturopathy:

> The dehumanisation of allopathic medicine disappointed me a lot. I totally refuse seeing a patient as a set of clinical analyses, of scans with a diagnosis and a label. … So, the patient turns into a superficial thing which is placed inside a folder. The highpoint of this is when allopaths, when they want to dig and to build a relationship with the patient, they won't be able to if they happen to be in a public institution. Why? Because currently the less time they spend with the patient, the more profitable they are. I usually spend rather than waste my time with the patient. (I21: TH)

One can denote here an attempt to lay jurisdictional claims to 'humanised care' and to show how this has been a much neglected area within allopathic medicine. Humanised care is justified through reference to the excesses of biomedicine, such as scientific and technological reductionism and the objectification of the patient. Additionally, Portuguese health policy's constraint on the length of patient consultations in the public healthcare service is blamed for compromising humanised doctor-patient relationships. It seems, therefore, that the claim of humanised care represents a countervailing value as it emphasises a return to a broader sense of 'care' which has been lost by conventional healthcare over time.

Preventative care and health promotion

Along with holism, illness prevention and health awareness were other significant countervailing values expressed by both traditional acupuncturists and traditional homeopaths. Yet, for the most part, preventative care remained an ideal. As one traditional acupuncturist leader and a representative of one of the most popular associations of

traditional acupuncture in the country – *The Professional Association of Acupuncture and Traditional Chinese Medicine* (APAMTC) – clearly put it, illness prevention depends not only on practitioners' and patients' changing attitudes, but also on structural factors, such as the delayed statutory policy on CAM in the country:

> Acupuncture has been spreading and currently it's quite easy [practising it]. [Yet] not in the way we would like to practise though, which would be preventing … The goal of Chinese Medicine is preventing and not treating. As we [CAM practitioners] haven't been able to legalise our status, I mean, the Act [45/2003] is already approved but there is no regulation yet, the result is a lack of State insurance and coverage. There is nothing basically, and this has prevented people from opting for CAM more often … look, they only opt for CAM as a last resort. And this is bad. (I6: TA)

The reference to the State as a main source of CAM legitimacy in Portugal is significant in this quotation. Specifically the Portuguese State is blamed here for not fostering the preventative care that could be delivered by acupuncture. TCM is believed to be more preventative than curative. The next statement illustrates how this participant emphasised health promotion as a potential factor in encouraging preventative care in Portugal:

> Int: So, when should we see the acupuncturist?
>
> R: Always. … Particularly when we haven't got ill yet. … That's the right time to see the acupuncturist… the Chinese Medicine [therapist] … This is the main message [I give to patients]. (I3: TA)

This respondent acknowledged that prevention meant consulting the acupuncturist in a healthy state and in the absence of disease. His comment implies that promoting preventative care may involve changing long-standing lay attitudes towards health, as patients tend to see the doctor only when they feel ill. In a sense, this respondent attempted to shift 'the direction of imputation of sin and moral failure in relation to not only illness, but lifestyle lapses' (Lowenberg and David 1994:589). One can see the attempt of this respondent to make the 'healthy person' a main target of intervention for CAM. This may represent a shift in the

opposite direction towards medicalisation. By claiming responsibility for preventative care, CAM practitioners acquire jurisdiction over the 'healthy person' who engages in perpetual care. This emphasis on a salutocratic society '… in which health is the reigning value' (Lowenberg and Davis 1994:595), has had as a consequence, as Lowenberg and Davis (1994) proposed, broadened the pathogenic sphere, by extending it to everyday problems such as lifestyle change and placing it under CAM scrutiny.

In summary, preventative care is clearly an area about which traditional acupuncturists and traditional homeopaths have made jurisdictional claims, at least at the conceptual level. In the same way as holism, preventative care and health awareness represented 'legitimacy values' in a countervailing form, in that their expression could be seen as an attempt to counterbalance excesses of the biomedical model - such as the overemphasis on curing disease. This process of highlighting the importance of health and well-being by raising people's awareness of the risks to their health and by emphasising the need for them to adopt healthy life-styles, constitutes what previous authors (Conrad 1992) have called 'healthicisation'. Healthicisation has been conceptualised as the process by which 'behavioural and social definitions are advanced for previously biomedically defined events (e.g. heart disease)' (Conrad 1992:223).

Alternative healing

There is strong evidence that providing alternative care in certain 'residual medical areas' has been a main strategy for CAM practitioners to seek legitimacy. For example, one of the reasons why acupuncture is at the forefront of CAM's attempt to self-regulate in many Western countries is because of its promotion as a more 'gentle alternative' to the biomedical management of pain (Saks 1995), which often deals with pain chemically and not uncommonly with minimal success. Traditional acupuncturists often mentioned palliation as a main area of intervention. Pain management in cases of rheumatology and lower back pain, for instance, were referred to by the following rank-and-file traditional acupuncturist:

> Imagine somebody with sciatica or a lower back pain … what do they usually get from the hospital? [They] will do [clinical] analyses, they may have to do loads of other things. An x-ray, perhaps a CT scan, and then you'll take a cocktail of *Voltarol* and

> *Relmus* and many other things. And a reasonable acupuncturist can find out if it is a lower back pain or sciatica just by observation and palpations. And with four or five needles [the practitioner] can make the patient feel the pain has been relieved. And after three, four days, the patient should get better. (I5: TA)

This quotation is very interesting as it contrasts different diagnoses and solutions to medical problems such as lower back pain. On the one hand, medicalisation of lower back pain is mentioned through an emphasis on high-technology medicine and invasive chemical medication. On the other hand, an alternative to medicalisation is offered, through an emphasis on more gentle and traditional ways of diagnoses, such as observation and palpation, and treatment, such as acupuncture needles.

The attempt to provide an alternative system of healing to biomedicine in residual medical conditions was also evident among traditional homeopaths. Skin problems and children's persistent throat infections, for instance, were two residual medical conditions often referred to by these practitioners as successfully treated with homeopathy. However, traditional homeopaths generally showed more resistance in redefining the boundaries of their practice than traditional acupuncturists. They legitimised homeopathy as a 'medical system' totally distinct from the biomedicine and emphasised the useless and invasive nature of some biomedical procedures in treating certain medical conditions. As one rank-and-file traditional homeopath put it:

> I was fed up of getting involved with 'anti' medication. … And then I found myself doing an inventory of the therapeutic weapons that alopathic medicine's got. Besides the antibiotics, which solve some situations. .... by killing the infectious bacteria, I cannot see any more remedies solving any other situation. All of these 'anti' remedies they don't really solve the problem. They just destroy the symptoms. (I21: TH)

The biomedical approach to healing where 'an opposite cures an opposite' is often criticised and opposed to the homeopathic world view when 'a similar cures a similar'. Furthermore, this respondent questioned the therapeutic superiority of biomedicine by referring to the antibiotic as its only real curative measure.

In summary, alternative healing in residual medical areas represents a countervailing value for respondents in that it implies using CAM definitions, treatments and solutions in medical areas where the degree of medicalisation at the interactional level has been weak and therefore where opportunities for poaching are greater. This aspect is also suggestive of CAM as an alternative rather than complement to medicalisation, evoking the demedicalisation of certain health problems, as some medical interventions to health problems are no longer appropriate and can be usurped by CAM.

Clinical pragmatism

Quah (2003), in her research on TCM in Singapore, states that this therapy's practitioners tend to adopt an 'ethos of pragmatic healing' as a temporary response to its incongruity with the ethos of science. Adopting a pragmatic ethos or disposition towards healing means legitimating an approach to healing which is less informed by scientific evidence than by clinical experience. This ethos is clearly illustrated by an acupuncturist leader who claimed a 'clinical transdisciplinarity' which he defined in the following manner:

> Medicine for me is the capacity to get results, doesn't matter what the technique being used is. It can be dancing around the person. It's the cure. … or the patient's progress. … So, it doesn't matter if it's homeopathy, or something else … Look, if somebody likes showing off in a religious way or doing a roly poly, what's the matter with that? If they're happy, they should keep doing it. (I6: TA)

This quotation illustrates well how exploratory this respondent's discourse is as, dance therapy, homeopathy, religious healing or movement therapy are all used to legitimate non-scientifically based healing paths. A significant clinical pragmatism is therefore present here, in that the importance of achieving an 'end' (a cure or the patient's clinical progress) is intensified, while the paths to achieving that end are extended to approaches other than merely scientifically informed ones. As stated by one acupuncturist: 'we get the evidence through the outcome' (I5: TA).

Having a pragmatic disposition to healing was also justified by all the respondents through claims about the 'unique experience' and the 'clinical idiosyncrasy' of the healing process.

They claimed that every process of healing varies as the time and place of healing, the illness condition, and type of healer and patient all vary. For example, as one rank-and-file traditional acupuncturist explained:

> If I decided to see a patient who I was about to see only tomorrow and if I decided to treat them [right now in the day time], then everything would be different from seeing them at night time and then perhaps the treatment would be different too. And [the consultation process] would be even more different if another colleague [and not me] happened to see them [the patient]. Because it isn't just a matter of pressure points … Because there isn't a protocol for each condition. … Diseases are not static. (I3: TA)

The importance given by this interviewee to the indeterminacy of the healing process during acupuncture, which includes the practitioner's idiosyncrasies or the changeable state of the illness condition, is evident. The reference to such indeterminacy often appeared as an attempt to legitimise clinical pragmatism in CAM practice and to undervalue standardised biomedical guidelines for healing.

Clinical pragmatism also undermines scientific evidence by emphasising evidence based on history and on clinical experience. For example, traditional acupuncturists saw acupuncture's approach to healing as being scientifically proven through history, rather than through the 'conventional scientific methods' set by biomedicine. As a traditional acupuncturist leader disclosed:

> But [acupuncture] is already scientifically proven through a scientific approach but in a different way. So, I mean, there are billions of people that have been treated for certain pathologies [through acupuncture] and we [Western medicine] are still using a different type of [biomedical] approach. So, we want to play rugby with tennis rules but that's something hard to do, you see. (I7: TA)

Although this participant's rhetoric entails viewing acupuncture as clearly more effective than biomedicine in treating certain pathologies, this treatment largely remains under the remit of conventional Western healthcare using a biomedical model. He explained this at a

metaphorical level by conveying the idea that treating certain pathologies using 'biomedical rules', legitimated by randomised controlled trials, may not result in successful treatment. In other words, he asserted that treating certain human problems with CAM may not be inappropriate.

In summary, it has been argued that holism, preventative care and health promotion, alternative healing and clinical pragmatism, as referred to by the respondents, are countervailing 'legitimacy values'. The promotion of these values was an attempt to counterbalance the imbalances of biomedical ideology and therefore mould the health marketplace to their own advantage. In a way, they have attempted to appropriate weak jurisdictional areas of medicine, but also other areas of life such as the promotion of health. The healthy person has thus become a main focus for the expansion of CAM.

Alongside the underscoring of countervailing values, traditional acupuncturists and traditional homeopaths also engaged in professionalisation strategies as a way to achieve occupational closure in Portugal. We will look at these strategies next.

Professionalisation through credentialism

Professionalisation strategies are inclusionary in that they clearly relate to the attainment of occupational closure mainly through the achievement of credentialism. CAM's professionalisation strategies have been in line with global health policy trends which have supported the rise of CAM practitioners' credentials in order for them to advance professionally. Increasing 'institutional' and 'occupational' credentialism (Freidson 1986) illustrates the main professionalisation strategies used by the respondents in the research reported here. These strategies will now be considered in more detail.

Increasing institutional and occupational credentialism

Institutional and occupational credentialism of CAM in Portugal has increased especially since the approval of the Act 45/2003 which was passed in July 2003. For example, increasing the number of organisations which operate as legal entities to establish CAM credentialism, and increasing the number of CAM practitioners with a valid license to practise, are the main professionalisation strategies used by traditional acupuncturists and traditional homeopaths. These points were illustrated by a traditional homeopathic leader and

representative from the *School of Advanced Studies in Naturology* (*Estudos Avançados de Naturologia* - EAN):

> Int: What's the best way to know at the moment if a CAM practitioner is competent or not?
>
> R: By asking where they were trained. Asking for their professional credentials … first if they've got training, what's the length of it, what tutors they've got? And then also if they're registered in any Federation[2] or *Câmara*[3] which supervises, let's say, their professional activity. Because in order to start practising, they need to get training and get their license through an association, or federation, or syndicate, or any other corporate institution. (I14: TH)

This quotation is also representative of the growing desire of traditional homeopaths to acquire group cohesion by establishing self-governing bodies to regulate this therapy. The reference to umbrella bodies like the Federation, which supports the legitimacy of CAM practitioners in Portugal by promoting scientific, juridical and technical information among the different associations, and the CNNET, a post-CAM Act association, were good examples. The latter registers only 'trained naturologists', which are defined as applicants who joined a CAM course with at least a secondary school degree[4], who completed their higher education in CAM as well as their specialisation in a CAM therapy in a school accredited by CNNET, and who completed internships in clinics under the supervision of a registered specialist accredited by the 'Câmara' (CNNET 2005). It was difficult however to obtain a precise number of homeopathic and acupuncture's associations and schools in the country associated with the umbrella bodies due to their multiplicity. This shows the heterogeneity surrounding CAM credentialism-making and that creating the conditions to raise CAM's standards through education has been a challenge for CAM practitioners. So although CAM promotion has been present at the institutional level, the internal disagreements around CAM credentialism-making and the holding-up of CAM regulation by the State have reduced its impact.

We now move to a third type of strategy used by traditional acupuncturists and traditional

homeopaths in their attempt to encroach upon Portuguese mainstream healthcare. This involves forming strategic alliances with biomedical science.

Forming Alliances with Biomedical Science

Strategic alliances as defined in this research are strategies used by CAM practitioners to foster their relationship with biomedical science in order to increase their opportunities to promote CAM in health and healthcare. On the surface, this seems a contradiction as allying with biomedical science means relying often on values which are contradictory to the 'legitimacy values' previously presented. Furthermore, the strategy of allying CAM with biomedical science is in line with the World Health Organisation's (WHO) guidelines on developing a sustainable use of CAM in Western countries. We now turn to look at each of these strategies in more depth.

Infusing CAM with elements of biomedical science

The high symbolic value of biomedical science that traditional acupuncturists and traditional homeopaths acknowledge can be seen as a status enhancement technique and therefore a way of acquiring greater legitimacy. The following insightful quotation is from a traditional homeopathic leader involved in homeopathic credentialism in Portugal, who appeared to use biomedical knowledge tacitly to legitimate the status of homeopathy:

> I'm gonna be honest with you… there are two stances … And I support both of them. I should support the [biomedical] education and training stance, but [there is also the stance that argues that] homeopathy doesn't need medicine at all. Homeopathy is a totally different science. But it depends on the country and on the public, you see. So, in Portugal homeopathy always needs to have biomedical support. (I12: TH)

This leader emphasised the need for homeopathy to foster alliances with the biomedical world by infusing it with biomedical learning in order to ensure its survival in Portuguese healthcare. Other CAM leaders, although distinguishing CAM from biomedicine, acknowledged that appropriating the symbolic value of biomedical knowledge would help them to enhance their status in a country where the rhetoric of 'biomedical power' remains dominant (Carapinheiro 2005). Therefore, not surprisingly, many acupuncture and homeopathic schools in Portugal have included the teaching of biomedical subjects such as

anatomy, clinical pathology and physiology in their curricula.

The infusion of biomedical science with CAM therefore has entailed the accommodation of scientific evidence. For most participants, this consequence was perceived as a way of coping with statutory barriers and helping acupuncture and homeopathy detach themselves from charlatanism. The following statement shows the ironic view of a traditional homeopathic leader when referring to scientific evidence:

> Int: Do you think that's important [to homeopathy] to get scientific evidence?
>
> R: Yes, I think it is. To stop definitely this situation [of CAM's marginalisation in the country]. We are charlatans … (I13: TH)

Whilst being seen as a main ingredient of biomedical knowledge, scientific evidence did not seem to constitute a main criterion to practise homeopathy for this practitioner. Yet other respondents, mainly CAM leaders who have been involved in statutory regulation, were sympathetic to scientific evidence and were keenly aware of the importance of acting in line with it in order to prevent medical doctors from labelling traditional homeopaths as quacks.

At the conceptual level, infusing CAM with biomedical language was also indicative of a strategic alliance between traditional acupuncturists and homeopaths and the medical profession. The discourse of the following traditional homeopath is clear in its use of biomedical language:

> … Headaches for instance … [imagine] if you get a migraine, not a regular headache … OK, I'll give you a non-steroid anti-inflammatory or rather I'll give you an anti-migraine pill with dubious effects. The anti-migraine stuff, more than 50% of that is considered ineffective. They nearly drop to the same level as placebo, which has only got a success rate of 30%. Water's memory [homeopathic theory] has got the same 30% as anti-migraine's medication. (I21: TH)

It appears that by externalising a biomedical discourse, traditional homeopaths and traditional

acupuncturists attempted to improve their status and convey the idea that they were 'complying with the rules' of the biomedical game. The convergence with biomedical science provided them with higher levels of public trust and therefore offered them opportunities to create better conditions for promoting CAM in health and healthcare.

Promoting integrative medicine

According to the WHO (2002), integrative medicine practised in clinical settings such as private clinics or hospitals has recently emerged in Western countries. Mizrachi et al's (2005) study of the recent collaborative patterns between orthodox medical doctors and CAM practitioners in hospital settings in Israel provides clear evidence of this. The emergence of integrative medicine represents a shift away 'from separating therapeutic modalities into categories such as 'biomedical' or 'alternative', towards a focus on merging diverse modalities into a 'new' integrative health system' (Hollenberg 2006:732). This shift can be seen as a recent strategy of CAM practitioners to be included in mainstream healthcare. By interacting with medical doctors and by sharing work settings, CAM practitioners have attempted to increase levels of public trust and survive in the marketplace.

According to Wiese et al. (2010), integrative medicine in its ideal form is concerned with collaboration and mutual respect between different medical systems. For the most part, traditional acupuncturists and traditional homeopaths were keen on working in partnership with medical doctors. Nurturing a referral relationship with medical doctors and with other biomedical professionals was a strategic alliance which was often referred to. As the following traditional acupuncturist leader disclosed:

> I have found more and more medical doctors open to … I have many patients whose doctors have referred them to me, I have many doctors as patients, I have many doctors' relatives as patients … Let's say that [acupuncture's results] might have to do with individual characteristics … with the results achieved and the individual work of each practitioner, right. (I7: TA)

What can be concluded from this last quotation is that the negotiation of the relationship between traditional acupuncturists and medical doctors is carried out for the most part at an interactional level, being dependent on contextual factors such as the 'likeability' and

'affinity' (Lerner 2008) of both professionals. At an institutional level, however, improving the relationship between CAM and biomedicine remains illusory, as the following statement from a traditional homeopathic leader and a representative from the APH clearly shows:

> Int: What's the difference between traditional homeopaths and medical homeopaths?
>
> R: It's a matter of elitism, nothing more. I know great medical homeopaths. Doctors, really. … We don't get on badly with the medical homeopaths. … The point is the Medical Council. And not the medical homeopaths. It's the Medical Council which doesn't want to have anything to do with us, so … it's just a matter of competition. (I12: TH)

Thus, despite the WHO's (2002) recommendations about collaboration between biomedicine and CAM therapies and the efforts of CAM practitioners to foster integrative medicine, the latter has remained idealistic in Portugal. Incorporation rather than integration has been the predominant form of CAM inclusion in Portuguese mainstream healthcare.

Discussion

This paper has addressed the following research question: what main strategies have CAM practitioners used to be included in mainstream healthcare in Portugal? The main strategies used by CAM practitioners at an interactional, institutional and conceptual level in order to acquire occupational closure in Portugal since the late 1990s have been analysed.

Traditional acupuncturists and traditional homeopaths have been presented as (re)active rather than passive actors in their relationship with the medical orthodoxy. From a neo-Weberian perspective, they have clearly activated strategies of closure to promote their interests in the healthcare field. Strategies of inclusion have been preferred. These have involved attributing blame to the biomedical model and seeking to counterbalance biomedical imbalances over time. For example, it appears that acupuncture and homeopathy have sought to gain control over work domains such as holistic care, preventative care and health awareness. In this paper, these themes were presented as 'legitimacy values' of a countervailing nature, i.e. values which tend to oppose, complement or represent an

alternative to biomedical values. The expression of countervailing values can thus be seen as a main strategy of CAM practitioners to control jurisdictional spaces left open by biomedicine.

A main theme emerging from the analysis of countervailing values was the proposed shift towards a patient-based approach to health. In the case of holism, the shift from an emphasis on the symptom to an emphasis on the patient was clear at both the institutional and the interactional level. In the case of prevention and health awareness, a shift from curative to preventative care which implies the patient's responsibility towards their health was highlighted, at least at a conceptual level. Alternative care, in turn, was often legitimised through an emphasis on its benefits to the patient. Lastly, in the case of clinical pragmatism there was an emphasis on the idiosyncrasies of the patient in order to legitimise an approach to health less informed by scientific evidence. To summarise, the emphasis on the patient appeared to be an important resource for promoting acupuncture and homeopathic treatments within Portuguese healthcare.

The data obtained from elite actors in acupuncture and homeopathy have shown that these therapies have engaged with professionalisation strategies to achieve occupational closure. Nevertheless, there is a significant lack of 'group cohesion' (Kelner et al. 2006) and numerous internal factions still exist among schools and associations. The tension between the grassroots and the elite levels in CAM's interaction with medical orthodoxy was also evident. Medical 'elitism', or the belief of the medical profession that it is superior to other professions within healthcare, was seen by traditional acupuncturists and traditional homeopaths as being more apparent at the institutional rather than the rank-and-file level.

Forming alliances with the medical profession seemed to be another significant strategy of closure. At the conceptual level, infusing CAM with biomedical science was a key strategy employed by CAM practitioners. Yet at an interactional level, traditional acupuncturists and traditional homeopaths' accounts of their relationship with biomedical practitioners and their involvement in integrative care settings demonstrated how integrative care is perceived as idealistic. Together, these actions represent an attempt by CAM practitioners to ally CAM with biomedical science in order to achieve some of the benefits obtained by the medical

profession and biomedical science, such as high symbolic status. These actions are thus an important part of traditional acupuncturists and traditional homeopaths' attempts to promote their practice within healthcare.

The contradictory nature of the strategies used by traditional acupuncturists and traditional homeopaths to activate occupational closure has been clearly apparent in the data reported here. On the one hand, claims to demarcate themselves from biomedical science and professionals were made. On the other hand, strategic allegiances with biomedical science and sometimes directly with biomedical doctors were also found. Furthermore, while in certain situations claims for scientific evidence in support of CAM were emphasised, in other contexts the disposition towards pragmatic healing, the 'charismatic transmission of knowledge' (Cant 1996) and the authority of experience and the past were highlighted. Their claims as complementary practitioners who restore and rebalance health from invasive biomedical treatments contradicted their claims as practitioners who can present alternatives to certain biomedical procedures. Finally, in some research contexts a preventative focus was attributed to CAM, while in others the characteristics of CAM's curative powers were highlighted. These contradictions are reflective of a countervailing process by which traditional acupuncturists and traditional homeopaths within Portuguese mainstream healthcare seek to acquire legitimacy and perhaps of a postmodern turn in healthcare, with the emphasis on diversity (Bakx 1991).

It has been argued that the promotion of CAM has had some impact on the process of medicalisation of human conditions (Conrad 2007). The main outcome of CAM strategies has been the legitimation of CAM definitions for previously nonmedical or medical problems. These definitions stand in opposition to medical definitions, but at an interactional level they can overlap. This can be the case of chronic pain, for instance, which has been managed by chemical pills, by CAM treatments, or by a combination of the two. At the same time, it could be argued that the legitimation of CAM definitions can boost the demedicalisation process of certain conditions, as some residual medical problems for which biomedicine has not found a proper solution have been increasingly transformed into problems to be treated by CAM, at least at the conceptual and also the interactional level. Chronic pain is again a good example. And if one takes into consideration the fact that more

and more medical doctors have incorporated CAM into their medical practice, it can also be argued that CAM promotion has lead to a remedicalisation process. Research on the extent to which CAM attempts to acquire occupational closure within Portuguese orthodox healthcare have been successful and the degree to which CAM promotion has impacted on the medicalisation process of certain human conditions, at the interactional, institutional and conceptual levels, needs to be further explored.

NOTES

[1] This New Act 71/2013 is the result of a longstanding countervailing power relationship between CAM representatives, the medical profession and the State, that goes back to 1996. It replaces the Act 45/2003 passed in July 2003 by Portuguese Parliament. The present research was conducted in 2008/2009, therefore, all mentions about a CAM Act in this paper refer to the Act 45/2003.

[2] The participant is referring to the FENAMAN (Federação Nacional de Associações de Medicinas Alternativas Naturais – National Federation of Natural Alternative Medicine's Associations).

[3] The participant is referring to the CNNET, *Câmara Nacional dos Naturologistas e Especialistas das Terapêuticas Não Convencionais*, an aspiring CAM Council which was set up in 2008 with clear regulatory and disciplinary ambitions over CAM.

[4] Grade 12, the equivalent to the British A-level qualifications.

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