**CAM’s occupational closure in Portuguese healthcare:**

**Contradictions and challenges**

**Abstract**

This paper analyses strategies of closure recently enacted by complementary and alternative medicine (CAM) practitioners in order to achieve occupational control over work domains in healthcare, taking Portugal as an example. A combination of the neo-Weberian occupational closure theory of the professions and Abbott’s jurisdictional vacancy theory is proposed as the 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. Data analysis suggests that (1) professionalisation (2) alignment with biomedical science and (3) expressing ‘legitimating values’ of a countervailing nature have been three significant strategies CAM practitioners have used in an attempt to achieve market closure. It is argued that these strategies are contradictory; some involve allegiances, while others demarcation from biomedical science. A further outcome of these strategies is the promotion of CAM treatments and solutions in everyday life. The success of these strategies therefore, although helping to reinforce the biomedical model, may simultaneously help CAM to demarcate from it, posing thus challenges to mainstream healthcare.

**Keywords:** Portugal, complementary and alternative medicine, occupational closure, jurisdictional vacancy, healthcare

**Introduction**

The issue of the relationship between well-established and emerging and/or lower status occupations has been comprehensively researched in the sociology of professions. Within the healthcare arena, the conflict between medicine – seen as the prototype of a dominant healthcare profession (Freidson, 1970) – and other subordinate professions, such as nursing or midwifery, is a longstanding issue. In the last decades, however, in response to the ‘revival’ of complementary and alternative medicine (CAM) (Cant and Sharma, 1999) and the subsequent legitimacy claims made by CAM practitioners, sociological research on CAM practitioners as an emerging professional group and their changing relationship with the medical profession has increased in countries other than Portugal (Gale, 2014; Siahpush, 1999; Wiese et al., 2010; Winnick, 2007).

Little is known about CAM practitioners as an emerging professional group and their relationship with the medical profession in Portugal, despite the fact that recent changes in Portuguese legislation have placed the country amongst those where there is governmental support for CAM. Very recently, in July 2013, Portuguese parliament passed an Act (71/2013) which approved seven CAM therapies – acupuncture, chiropractic, homeopathy, naturopathy, osteopathy, phytotherapy and traditional Chinese medicine – and the implementation process is currently underway. Thus, it seems that Portugal has undergone a similar process to other countries, making it an interesting case for analysis.

The research reported here explores CAM practitioners as an emerging professional group and the recent strategies they have used in their attempts at social closure within Portuguese healthcare. The nature of these strategies and the potential challenges posed by them to orthodox healthcare and its prevailing biomedical model are also examined, taking Portugal as a case study.

**Background**

*A neo-Weberian approach to the professions*

Qualitative sociological research on the relationship between dominant healthcare professions and those who are subordinate and emerging has often adopted a neo-Weberian approach, or a closure theory, of professions. According to this approach, inter-professional relationships are relationships involving conflict over status, power and interests (Saks, 2012). Professional groups and/or individual professionals are agents of closure strategies (i.e. tactics, actions or mechanisms) and act in ways which protect their interests, maintain, gain or restrict power and status, and bring to fruition their wants or desires. Closure strategies can be inclusionary or exclusionary. The former tend to be typical of subordinate, emerging or professionalising groups, who usually fight for higher status and power within the marketplace. The latter are typically employed by dominant or professionalised groups such as the medical profession, who try to demarcate themselves from other related professions or emerging professional groups and restrict access to rewards and privileges (Parkin, 1979; Witz, 1992). According to Parkin (1979), professionalising groups also engage in dual closure strategies, containing elements of both inclusionary and exclusionary closure. For example, whilst fighting for recognition they also emphasise their distance from charlatanism and acquire ‘group cohesion’ (Kelner et al., 2006). As stated by Witz (1992), demarcationary strategies can be applied by subordinate occupational groups as a form of resistance towards dominant groups or as a way to consolidate their position within the division of labour (Witz, 1992).

Professionalisation, or the process by which occupational groups seek to constitute and control a market for their expertise (Larson, 1977), usually through acquiring credentialism (Freidson, 1986), has been extensively noted in the sociological literature as a main strategy of inclusion employed by professionalising groups such as CAM practitioners. Two main dimensions of this process are usually identified: structural changes (in Freidsonian terms, ‘institutional credentialism’), or changes in the way professional groups have organised and represented themselves, and knowledge changes (Freidson’s ‘occupational credentialism’), which are changes in the knowledge base of a professional group. The next section shows how the occupational closure theory of professions has been applied to the study of CAM.

*An occupational closure approach to CAM*

Sociologists have often used an occupational closure theory in their analysis of CAM practitioners’ attempts to acquire legitimacy in the healthcare market. Cant’s (1996) account of British traditional homeopaths and chiropractors, for example, has shown how the structural and knowledge dimensions of the professionalisation process of CAM have been intertwined: homeopaths’ and chiropractors’ attempts to professionalise in the 1990’s occurred in tandem with the creation of professional associations and accredited training courses, which, in turn, led to the development of scientific knowledge and to a ‘tempering of knowledge claims’ (Cant, 1996: 55).

Saks (2012) also suggests that CAM practitioners have used knowledge, skills and expertise ideologically to legitimise their professional status. His analysis (Saks, 1995) 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. In the same vein, Cant (1996) has shown how British traditional homeopaths and chiropractors have altered their knowledge base in order to ensure their survival within the system of professions, to develop a relationship of trust with the public, and to gain respect from the medical profession. In recent research, she (Cant, 2009) has illustrated how non-orthodox care in Britain has been increasingly shaped by biomedicine within the NHS, with the former achieving the status of ‘mainstream marginality’, through being integrated into healthcare but in biomedical terms. More recently, Givati (2015) and Givati and Hatton (2015) have suggested that CAM practitioners in Britain have engaged with ‘pragmatic holism’ and renegotiated their holistic claims, as a result of professionalising and aligning with biomedical science.

Evidence of the alignment of CAM with biomedical science has also been suggested by other studies (Hollenberg, 2006; Mizrachi et al., 2005; Shuval et al., 2002), which have looked at recent collaborative patterns between orthodox medical doctors and CAM practitioners in integrative healthcare settings. The emergence of integrative medicine represents a movement ‘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). By interacting with medical doctors, and by sharing work settings, CAM practitioners increase their levels of public trust and legitimacy, putting themselves in a better position to promote CAM within healthcare. Recent research (Broom and Tovey, 2007; Coulter, 2005; Hollenberg, 2006; Shuval et al., 2002), however, has analysed professional interactions between CAM practitioners and medical doctors in integrative healthcare settings and has suggested that CAM practitioners, although accepted, remain spatially, structurally and symbolically marginalised, and that their relationship with medical doctors remains distant and dominated by the latter.

Literature (Kelner et al, 2006) has also suggested that concomitantly with the increasing credentialism and the alignment with the so-called biomedical model, CAM practitioners have tried to appropriate healthcare jurisdictions left open by biomedicine. Abbott’s (1988) perspective on the professions and his jurisdictional vacancy theory are of great complementary value here and it is these to which we will now turn.

*CAM and jurisdictional vacancies*

According to Abbott (1988) the professions are committed to certain central legitimating values which define their ‘subjective character’ (or cognitive structure). The ‘subjective character’ of a profession embodies a certain diagnosis, inference and treatment which impose a subjective structure on the problems with which a profession works. Furthermore, professions live in an interactive and competitive system which is occasionally disturbed and readjusted by external forces. External forces affect individual professions and their ‘subjective character’, potentially creating ‘residual areas’ or problems and opening or closing spaces for jurisdictional poaching.

In the case of CAM therapies, these have promoted central legitimating values which define the subjective character of their profession and help it to acquire jurisdiction. Previous studies (Bakx, 1991; Jackson and Scambler, 2007) have suggested that holism has been a significant value used by CAM practitioners to demarcate from recent values promoted by medicine. Holism is largely associated with patient-centred approaches to healing, and the latter has been identified within the literature (Givati, 2015; Lowenberg and Davis, 1994) as a device used by CAM practitioners to counterbalance symptom-centred approaches of biomedicine; interestingly, it was also a device general practitioners (GPs) in Britain used 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), GPs could distinguish their general practice from other medical specialisms and secure their role within British medical practice.

Prevention has been another significant legitimating value, giving emphasis to a salucratic society ‘in which health is the reigning value’ (Lowenberg and David, 1994: 595). Lowenberg and David (1994) have singled this out as a significant device employed by holistic health practitioners in order to counterbalance the overemphasis of the biomedical model on curing diseases. Healthicisation, or the process by which ‘behavioural and social definitions are advanced for previously biomedically defined events (e.g. heart disease)’ (Conrad, 1992: 223), has broadened the pathogenic sphere by extending it to everyday problems such as lifestyle change (Lowenberg and David, 1994) and thereby placing it under CAM scrutiny.

Saks (1995) also suggests that one reason for acupuncture being at the forefront of CAM’s attempt to self-regulate in many Western countries is its promotion as a more ‘gentle alternative’ to the biomedical management of pain (Saks, 1995), which often deals with pain chemically, and commonly with minimal success. Chronic pain is a residual medical area with problems in its process of ‘medicalisation’ (Conrad, 2007), since there is no effective medical intervention or biomedical treatment for it. Alternative healing in residual medical areas such as chronic pain is an example of the increasing use of CAM definitions, treatments and solutions in cases where the degree of medicalisation has been weak, and therefore where opportunities for poaching and demedicalising are greater.

Lowenberg and Davis (1994) were among the few who discussed the contradictions inherent to holistic health with respect to medicalisation. For the authors, holistic health has represented a shift from medicalisation towards demedicalisation, as it returns the responsibility for health, illness, wellbeing and cure to the individual. However, it has simultaneously reinforced medicalisation and medical surveillance, as it extends the pathogenic paradigm and broadens the domains of life open to medical intervention. What is missing in Lowenberg and Davis’ (1994) study, however, is a reflection on the potential uses of CAM by different health professional groups, which could aid understanding of who the main drivers of the medicalisation and demedicalisation trends actually are in contemporary society.

Finally, Quah’s research (2003) on Traditional Chinese Medicine (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 claiming an approach to healing which is less informed by scientific evidence than by clinical experience or history. Jackson and Scambler’s study (2007) shows how traditional acupuncturists mentioned the long history of Chinese medicine, alongside their own clinical evidence, to indicate acupuncture’s functionality.

To conclude, CAM practitioners have acted as a professionalising group and enacted strategies of inclusion and demarcation in the healthcare market. They have professionalised and aligned with biomedical science, but have concurrently expressed legitimating values which have defined CAM’s subjective character and helped to appropriate healthcare jurisdictions left open by biomedicine. These have been identified by the literature as significant strategies used by CAM practitioners to achieve occupational closure within orthodox healthcare in Western countries other than Portugal. With this in mind,his paper I assess: (1) the strategies CAM practitioners have used to gain inclusion in Portuguese mainstream healthcare; (2) the nature of these strategies and their potential challenges to biomedicine, taking Portugal as a case study.

**Methods**

*Overview of the study design*

The study reported here was part of broader research focused on the changing relationship between CAM, the medical profession and the State since the late 1990s in Portugal. Acupuncture and homeopathy were chosen as two case studies. An important reason for choosing these two CAM therapies was that both are included in the list of seven CAMs under statutory regulation in Portugal. Furthermore, these two therapies are worth comparing because their statuses differ: 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.

*Participants*

Participants in the study reported here included 20 CAM practitioners, namely 10 traditional acupuncturists and 10 traditional homeopaths. The term ‘traditional’ refers here to non-medically qualified practitioners. Amongst the traditional acupuncturists seven were rank-and-file practitioners and three were members of the CAM elite and acupuncture leaders. Amongst the traditional homeopaths, five were rank-and-file practitioners and five homeopathic leaders. As the researcher wanted to sample participants in a strategic way in order to interview a wide diversity of people, purposive sampling procedures were adopted (Bryman, 2016). Conversations with ‘key informants’ and ‘gatekeepers’, and a preliminary analysis of documents such as CAM associations’ websites guided the purposive sampling process of CAM leaders. CAM leaders were selected on the basis of their key role in the regulation process of CAM. Rank-and-file practitioners were selected, as although not involved with CAM regulation they were seen as active members of their profession, accommodating the strategies set out by the leaders and thus acting to their own advantage. Rank-and-file practitioners were selected using the snowball technique, in which the researcher initially sampled a small number of people and used their social networks to reach other participants with characteristics suited to the research (Bryman, 2016; Silverman, 2013).

*Data Collection*

This paper specifically explores data obtained from in-depth interviews with traditional acupuncturists and traditional homeopaths. An open-ended topic guide was used during the interviews which covered thematic categories such as ‘CAM professionalisation and regulation’, ‘strategies to gain status/power within mainstream healthcare’ and ‘CAM challenges to the medical profession’. Participants were asked about their definitions of orthodox and non-orthodox medical practice, their views on the role, use and efficacy of CAM and on their relationship with medical doctors, and their perceptions of the use of CAM by medical doctors.

The sampling process of this study was an iterative process which constantly switched between sampling and theoretical reflection. Glaser and Strauss (1967) define this type of purposive sampling as ‘theoretical sampling’ and emphasise the use of theoretical reflection on data as a guide to whether more data needs to be collected. The author also employed theoretical saturation of data in her sample, which meant that when new data no longer stimulated the theoretical understanding of each thematic category she ceased collecting new data (Bryman, 2016).

The individual interviews were conducted across Portugal by the author between June 2008 and April 2009, an intense period of negotiation for CAM practitioners in the country, when a regulatory group was set up by the state to work on the guidelines and standards of practice for each CAM therapy. The interviews took place in a variety of public and private spaces: consulting rooms in clinics, universities, cafés, public gardens and interviewees’ homes. The average length of the interviews was two hours. Additional data included governmental and professional documents, used to complement analysis of the institutional dimension of the data.

All the interviews were audio recorded using an 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 transferred to the Atlas.ti5 program for storage and initial coding.

*Data Analysis*

The study presented here adopted a thematic analysis approach, which draws upon a search for and generation of recurring themes and subthemes after a thorough reading of the transcripts and initial familiarisation with the data (Bryman, 2016), Repetitions, similarities and differences, and links and connections with main topics from the literature review, were taken into account when searching for themes. From an initial, exhaustive analysis the author conglomerated these themes into wider, more abstract thematic categories. Finally, the author pieced together segments of data in each theme and developed an analysis of what traditional acupuncturists and traditional homeopaths said about each theme.

*Ethics*

The study discussed here acquired university ethics approval. Subsequently, an information sheet with details about the research was emailed 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 purposely omitted in order to protect the personal identities of participants.

*Terminology*

In the study reported here, CAM refers to ‘a broad set of health care practices that are not part of that country's own tradition and are not integrated into the dominant health care system’ (WHO, 2000: 1). The terms ‘biomedicine’, ‘biomedical model’ and ‘biomedical science’, in turn, refer to institutionalised medicine grounded in scientific knowledge and an evidence-based ethos which has political legitimacy (Saks, 2003).

*Limitations of the study*

The study reported upon here involved a small sample collected in one particular context. Therefore, generalisability is based on the plausibility of the strategies of occupational closure identified among CAM practitioners in Portugal during a particular period of time. Furthermore, the strategies used by the medical profession and the state in relation to CAM attempts at occupational closure, although being central to understand the process of CAM legitimacy in Portugal, were not considered in this paper, which focuses solely on CAM practitioners’ strategies.

I now turn to the investigation of the dominant closure strategies enacted by traditional acupuncturists and traditional homeopaths in a bid to acquire legitimacy in Portugal.

**Findings**

The findings presented here examine strategies of occupational closure enacted by CAM practitioners in their attempts to be integrated in Portuguese healthcare. Analysis of the interviews suggests that CAM practitioners’ strategies fall into three main themes: (1) professionalisation; (2) alignment with biomedical science; and (3) expressing ‘legitimating values’. I now turn to look at each of these strategies in more detail.

*Professionalisation*

Increasing ‘institutional’ and ‘occupational’ credentialism (Freidson, 1986) illustrates the main professionalisation strategy referred to by the respondents in the research reported here. Both forms of credentialism of CAM have increased in Portugal, particularly since 2003 when statutory regulation of CAM began. The main strategies employed were increasing the number of organisations which operate as legal entities in order to establish CAM credentialism, and increasing the number of CAM practitioners with a valid license to practise. These points were illustrated by a traditional homeopathic leader:

Int: What’s the best way of currently knowing if a CAM practitioner is competent or not?

R: By asking where they were trained. Asking for their professional credentials … firstly, if they’ve had training, the length of training, what tutors they have. And then also if they’re registered in any Federation or *Câmara* which supervises, let’s say, their professional activity because in order to start practising, they need training and to get their license through an association, federation, syndicate, or any other corporate institution. (I14: TH)

This quotation is representative of the growing desire of traditional homeopaths to acquire group cohesion by establishing self-governing bodies to regulate this therapy. Umbrella bodies, as discussed above, like the National Federation of Natural Alternative Medicine’s Associations (FENAMAN), which supports the legitimacy of CAM practitioners in Portugal by promoting scientific, juridical and technical information among the different associations, and the CNNET, an aspiring CAM Council (*Câmara*) which was set up in 2008 with clear regulatory and disciplinary ambitions over CAM, are good examples of these bodies. The latter only registers ‘trained naturologists’, defined as applicants who joined a CAM course with at least a high school degree, who completed their higher education in CAM as well as specialised 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).

A second type of strategy used by traditional acupuncturists and traditional homeopaths in their attempt at social closure involves aligning with biomedical science. We now move to this type of strategy.

*Alignment with biomedical science*

The alignment with biomedical science was expressed in two ways: (1) by infusing CAM with elements of biomedical science and (b) by promoting collaborative work.The infusion of CAM with elements of biomedical science has entailed the accommodation of scientific evidence. For most participants this was perceived as a way of coping with statutory barriers and helping acupuncture and homeopathy to detach themselves from charlatanism. The following statement shows the ironic view of a traditional homeopathic leader regarding 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 in the practice of homeopathy for this practitioner. Yet other respondents, mainly CAM leaders who have been involved in statutory regulation, were sympathetic to scientific evidence and keenly aware of the importance of acting in line with it in order to avoid medical doctors labelling traditional homeopaths as quacks. Therefore, unsurprisingly, many acupuncture and homeopathic schools in Portugal have included the teaching of biomedical subjects in their curricula, such as anatomy, clinical pathology and physiology. The following insightful quotation is from a traditional homeopathic leader involved in homeopathic credentialism in Portugal, who emphasised the need for homeopathy to foster alliances with the biomedical world by infusing it with biomedical learning so as to ensure its survival in Portuguese healthcare:

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)

At the conceptual level, infusing CAM with biomedical language is also indicative of a strategic alignment of traditional acupuncturists and homeopaths with biomedical science. 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 acupuncturists attempted to improve their status and convey that they were ‘complying with the rules’ of the biomedical game.

Another indication of CAM practitioners’ alignment with biomedical science was the mention to collaborative work.For the most part, traditional acupuncturists and homeopaths were keen to work cooperatively, often referring to their nurturing of a referral relationship with medical doctors and other biomedical professionals. As the following traditional acupuncturist leader disclosed:

I have found more and more medical doctors open to [CAM] … I have many patients whose doctors have referred them to me, I have many doctors as patients, I have many doctors’ relatives as patients … (I7: TA)

One traditional homeopathic leader and representative of the APH, when asked about the differences between traditional homeopaths and medical homeopaths, clearly differentiated between the interactional and institutional levels:

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)

We can conclude from this quotation that the relationship between traditional homeopaths and medical doctors is mostly based on interactional elements, since that at the institutional level of the Medical Council that relationship remains illusory.

Alongside professionalisation and alignment with biomedical science, traditional acupuncturists and traditional homeopaths also expressed legitimating values. We will look at these next.

*Expressing ‘legitimating values’*

The main legitimating values referred to by traditional acupuncturists and traditional homeopaths in the study reported here are: (1) Holism; (2) preventative care and health promotion; (3) management of pain and chronic conditions and (4) clinical pragmatism. All of these values are of a demarcationary and countervailing nature, as their expression could be seen as an attempt to distinguish their practice from biomedicine and counterbalance the perceived excesses of the biomedical model. We will now look at each of them.

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 traditional Chinese medicine (TCM) 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)

This statement clearly indicates that being a ‘traditional acupuncturist’ is currently defined as the opposite of being a ‘doctor’. The respondent highlighted the social environment of patients, and not just the physiological aspects of the ill body. References to holistic health were frequently accompanied by an emphasis on restorative care and the rebalancing of health. As one homeopathic leader pointed out:

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 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) following invasive biomedical procedures. Such imbalances may provide an opportunity for CAM practitioners to encroach upon mainstream healthcare, as they claim the ability to deal with conditions arising from the adverse effects of certain biomedical measures (such as surgery).

Claims for the usefulness of 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. … I usually spend rather than waste my time with the patient. (I21: TH)

One can see here an attempt to lay jurisdictional claims to ‘humanised care’ and to show that this has been a much neglected area within allopathic medicine. Humanised care is justified through reference to scientific and technological reductionism and the objectification of the patient.

Along with holism, preventative care and health promotion were other significant legitimating values expressed by both traditional acupuncturists and traditional homeopaths. Yet, for the most part, preventative care remained an ideal. As one traditional acupuncturist leaderclearly stated, 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 … 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. (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. Traditional Chinese medicine is believed by this respondent to be more preventative than curative. The next statement illustrates this participant’s emphasis on 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 public attitudes towards health, as patients tend to see the doctor only when they feel ill.

Alongside holism and preventative care, 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 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 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 with an emphasis on high-technology medicine, invasive chemical medication and mainstream healthcare settings and professionals. On the other hand, an alternative to medicalisation is offered, focusing on the role of traditional acupuncturists in finding more gentle and traditional ways of diagnosing, such as observation and palpation, and treatment, such as acupuncture needles.

The attempt to provide alternative modes of healing beyond 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 regarded as successfully treatable with homeopathy by these practitioners. However, traditional homeopaths generally showed more resistance to redefining the boundaries of their practice than traditional acupuncturists. They legitimised homeopathy as a ‘medical system’ totally distinct from biomedicine, and emphasised the useless and invasive nature of some biomedical procedures in treating certain medical conditions.

Finally, clinical pragmatismis 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. (I6: TA)

In this quotation, the importance of achieving an ‘end’ (a cure or the patient’s clinical progress) is highlighted, and the path to achieving that end is 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. 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 (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, is evident.

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

[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 on 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.

**Discussion**

This paper has assessed strategies of occupational closure used by CAM practitioners in their attempts to be integrated into Portuguese healthcare. Strategies of inclusion and demarcation were seen here to be the preferred method, corroborating thus previous literature (Cant, 2009; Givati, 2015; Kelner et al., 2006; Saks, 1995). Data obtained from documents and elite actors in acupuncture and homeopathy have shown that CAM practitioners have engaged with professionalisation strategies, with institutional and occupational credentialism (Freidson, 1986) being the most illustrative ones. The data presented showed CAM practitioners’ attempts to create professional associations and accredited training courses, as in countries such as the UK, the US, Canada and Australia. This increasing credentialism demonstrates CAM practitioners’ attempts to acquire group cohesion and demarcate from charlatanism in the country.

Alongside professionalisation, the use of knowledge, skills and expertise ideologically to legitimate CAM practice (Saks, 2012) was also noted. The alignment with biomedical science is illustrative of this strategic use. CAM practitioners have suggested a renegotiation or ‘tempering of knowledge claims’ (Cant, 1996: 55; Givati, 2015) and an attempt to restrict CAM’s knowledge base in order to ensure its survival within healthcare. This is the case when considering preventative care and the management of pain and chronic conditions. As other studies have suggested (Cant, 1996; Saks, 1995), the allegiance with biomedical science and knowledge might provide higher levels of public trust and, therefore, offer opportunities to create better conditions for promoting CAM in healthcare. Yet, despite the WHO’s (2013) recommendations about collaboration between biomedicine and CAM therapies, traditional acupuncturists’ and traditional homeopaths’ accounts of their relationship with biomedical practitioners have demonstrated that collaborative care is perceived as idealistic (see Hollenberg, 2006; Shuval et al., 2002). Nevertheless, using biomedical expertise seems to be extremely, yet strategically, important for CAM practitioners to legitimate their practice and consolidate their position within Portuguese healthcare.

CAM practitioners however have also attributed blame to the biomedical model, sought to demarcate from it and counterbalanced biomedical imbalances over time. For example, it appears that acupuncturists and homeopathy practitioners have sought to gain control over work domains such as holistic care, preventative care, health promotion and management of pain and chronic conditions. In this paper, these themes were presented as ‘legitimating values’ which define CAM’s ‘subjective character’ or approach to human problems (Abbott, 1988). These values have been identified as being of a demarcationary and countervailing nature, that is, they are values which tend to demarcate from and challenge recent biomedical reductionism, curative care and the emphasis on illness and disease. The expression of these values can thus be seen as a major strategy by CAM practitioners to demarcate from the medical profession and control jurisdictional spaces left open by biomedicine (Abbott, 1988).

A core theme emerging from the analysis of legitimating 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; humanised care represented a countervailing value through its emphasis on a return to a broader sense of ‘care’ which has arguably been lost by conventional healthcare over time. In the case of prevention and health awareness, a shift from curative to preventative care which implies the patient’s responsibility for their own health was highlighted. Most of the respondents attempted to shift ‘the direction of imputation of sin and moral failure in relation to not only illness, but lifestyle lapses’ (Lowenberg and Davis, 1994: 589). 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. Similar to previous research (Jackson and Scambler, 2007; Quah, 2003), the reference to the indeterminacy of the healing process, which includes practitioners, patients and illness idiosyncrasies, often appeared as an attempt to legitimise clinical pragmatism or a ‘pragmatic ethos’ (Quah, 2003) in CAM practice and to undervalue standardised biomedical guidelines for healing.

The significance of the ‘healthy patient’ was also notable. The data presented here have shown the attempts of CAM practitioners to make the ‘healthy person’ a main target of intervention for CAM and a main focus for the expansion of CAM. This may represent a shift in the opposite direction from medicalisation, as Lowenberg and David (1994) have suggested. By claiming responsibility for preventative care, CAM practitioners acquire jurisdiction over the ‘healthy person’ who engages in perpetual care; and by shifting the ‘gaze’ from being focused on the individual and their disease, to being focused on the individual in relation to their social context, CAM practitioners can promote opportunities for demedicalising certain conditions. This has been seen as more evident with residual medical problems for which biomedicine has not found a proper solution, with chronic pain being a good example. To summarise, healthicisation and demedicalisation (Conrad, 2007) appeared to be important resources for legitimating CAM practice within Portuguese healthcare.

The findings reported here have suggested thus a contradictory dynamic whereby traditional acupuncturists and homeopaths activate occupational closure. On the one hand, strategic allegiances with biomedical science were evident. On the other, claims of demarcating themselves from biomedical science and professionals were made. Depending on the success of these strategies, CAM practitioners can create challenges to Portuguese orthodox healthcare and its biomedical model. For, although reinforcing the continuing influence of the biomedical model in healthcare by aligning to it, they also have sought to revive values lost by biomedicine over time. Lowenberg and David’s (1994) assumption that holistic health has served to reinforce the biomedical model of healthcare and so contributed to broadening the scope of medicalisation, would have to be revised in light of a variety of professionals embracing CAM. The study reported here suggests that CAM practitioners in Portugal have allied with biomedical science and knowledge but only strategically, and to an extent, as they have clearly used demedicalisation and healthicisation in order to activate social closure. This perhaps reflects an attempt at a postmodern or ‘post-scientific’ (Moore & McClean, 2010) turn in Portuguese healthcare, with its emphasis on a plurality of health practices and ideologies rather than on the hegemonic power of biomedical science.

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