POWER AND PROFESSIONALISATION IN CAM
A sociological approach

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I Defining CAM: the centrality of power

This chapter will set out a sociological approach to complementary and alternative medicine (CAM) in Western societies in general and Britain in particular, with a focus on power and professionalisation in CAM. Too often, this latter concept is seen statically in terms of a group of specific therapies, which are frequently viewed as either traditionally or holistically based. Aside from the fact that only some CAM therapies have long historical roots or take a whole-person approach philosophically and in their practical orientation to the client (see, for example, Coward 1989), developing a definition based on a fixed cluster of therapies does not capture the dynamic nature of CAM in the West. This is best conceptualised as fluidly related to orthodox medicine – the boundaries of both of which are interlinked and change over time (Saks 2003). CAM is therefore defined here in terms of its subordinated position in relation to orthodox health care, centred on the marginality of CAM practitioners in relation to power in the occupational division of labour.

In this sense, orthodox medicine is viewed sociologically as health care underwritten by the state, which is at present based on biomedical dominance and focused heavily on drugs and surgery (as highlighted by Le Fanu 2011). CAM conversely is viewed as those therapies usually not supported by the state and currently largely subordinated to biomedicine (see, for example, Saks 1992a). As such, in Western societies, CAM covers a great range of approaches, from acupuncture and aromatherapy through herbalism and homeopathy to naturopathy and reflexology. The diverse therapies contained under the umbrella of CAM, moreover, do not necessarily form in any sense a coherent set of practices, except in so far as they are marginalised; the line between medical orthodoxy and the nature of CAM may therefore vary not only historically (Saks 2005a), but also between specific societies and different parts of the world – from Western societies like Britain and the United States to Eastern countries such as China and India (see, for instance, Adams et al. 2012).

The interpretation of CAM in this sense is inevitably shaped by theoretical perspectives. My own neo-Weberian approach is based on the concept of exclusionary social closure in the market giving rise to professionalisation (Saks 2010). On this approach, CAM is viewed as a marginal area in terms of the associated creation of bodies of insiders and outsiders through
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legally enshrined social closure in which medicine and the allied health professions have generally captured the higher political ground. In this respect, CAM is defined in terms of its subordination in the politics of health – and is not simply held to be those therapies that lack available scientific evidence as regards efficacy and effectiveness compared to orthodox medicine (see, for example, Wallis and Morley 1976). This latter view is contentious and can be seen as a part of the dominant ideology of the medical profession in a fluid political game underpinned by group interests involving critical debates about what orthodox medicine has achieved in practice and what is to count as evidence in this discussion (Richardson and Saks 2013).

The essence of the definition of CAM subscribed to in this sociological approach, therefore, is that its constituent therapies are not based on homogeneous intrinsic characteristics, but rather on their politically marginalised position (Saks 2008). Depending on the balance of power, therefore, the orthodoxy of one period can become the unorthodoxy of another, and vice versa. As the title suggests, while CAM can be used in a complementary, more politically acceptable way, to orthodox medicine, it can also be used in a more challenging manner in providing alternative patterns of health care to orthodoxy. This can be illustrated by the complementary use of osteopathy to treat the mechanical aspects of musculo-skeletal problems for which prescribed medicine like analgesics and anti-inflammatory drugs are being given. This contrasts with using alternative therapies like herbalism in place of orthodox medication for conditions such as allergies and asthma (Stone and Katz 2005). However, in all such guises, CAM represents different shades of marginal practice. Central to the process of marginalisation is the crucial notion of professionalisation based on legally bounded exclusionary social closure in the marketplace of occupations which – in elevating the standing of orthodox medicine – underwrites the lack of power of CAM practitioners and their position as outsiders (Saks 2002).

This neo-Weberian view of professionalisation based on the operation of power and interests in the market provides a stronger framework for the analysis of CAM than many other theoretical perspectives since it is centred on a relatively non-assumptive model about the core differentiating characteristics of professional and non-professional groups in simply recognising the legally underpinned existence of professions linked to exclusionary social closure (Saks 2010). This contrasts with the longer standing trait and functionalist approaches to professions which, as part of their very definitions of these groups, reflexively see ‘top dog’ professions like medicine as rather flatteringly centred on their distinctiveness in terms of such features as high-level expertise, rationality and altruism (see, for instance, Greenwood 1957 and Goode 1960) – while those outside such professions, including semi-professions like nursing, are not thought to have such fully developed characteristics in these areas and this is held to account for their lower position in the pecking order (Etzioni 1969).

More critical approaches to professionalisation linked to the 1960s/70s counter culture and beyond – such as interactionism, Marxism and Foucauldianism – also have their virtues in providing a challenge to the previously dominant orthodoxy. Nonetheless, unlike the neo-Weberian perspective based on seeing professions as a form of market control, they fall foul of the criticism of making rather too many constraining assumptions, albeit in a negative rather than a positive direction. The interactionists typically base their analysis at a micro-level on the largely non-substantiated premise that there is no real difference between professionals and non-professionals – and that being a member of a profession means little more than possessing an honorific symbol (see, for example, Becker 1962 and Hughes 1963). Marxists, meanwhile, tend reflexively and somewhat tautologically to see the operation and role of professions as serving the interests of the capitalist state (as illustrated by Esland 1980), while Foucauldians debunk the ideology of progress associated with professions by employing a concept of governmentality that is very difficult to operationalise (Johnson 1995) and playing fast and loose with the evidence (Foucault 1989).
However, it is argued here that the neo-Weberian approach provides a more productive framework for analysing professionalisation, not least in the context of the position of CAM, and adds to a greater extent to our understanding of its historical dynamics in a wider socio-political environment. Without claiming that the neo-Weberian approach is always applied appropriately (Saks 2010), its particular strength is that it allows us to grasp in an evidential manner the role of power and group interests in the development of health care and other related professionalised fields, including their representation in the contemporary occupational division of labour. Pleasingly, the approach has also been applied in a manner designed to enable the understanding of gender in the politics of professionalisation (Witz 1992) – a dimension that, as will be seen in this and other chapters in this volume, is also important in understanding the marginality of CAM. All of this is highly applicable to examining the interface between orthodox medicine and CAM within a neo-Weberian framework to which we now turn from a historical viewpoint, with particular reference to the political marginalisation of CAM in Britain.

II The political marginalisation of CAM

Here it is crucial to understand that pre-industrial health care in Britain up to the mid-nineteenth century was historically characterised by a comparatively undifferentiated field, with the absence of a nationally enforceable legal monopoly of medicine in neo-Weberian terms (Saks 2005a). In this environment, in which women were traditionally important players both as healers and in their health care role in the home (see, for instance, Oakley 1992), it was very difficult to differentiate practitioners involved in the delivery of health care. While those involved used a broad plethora of practices, which ranged from patent medicine with secret formulae to heroic medicine like bleeding and cupping, their training was often based on apprenticeships and they made parallel use of medical theories and language. Practitioners were also largely indistinguishable in terms of repute. Indeed, at this time there was no central reference point from which to judge best practice – with serious caveats about the knowledge, integrity and modus operandi of even some of those groups that were later to become professionalised. As such, in the first half of the nineteenth century in Britain, groups like apothecaries and surgeons, who became part of the new medical orthodoxy, co-existed with competitors such as herbalists and homeopaths in a mainly open field in which participants hawked their wares in the market for practitioners and self-help remedies (Porter 1995).

This relatively open pluralistic health care field was to be superseded, however, with the creation of a medical profession in Britain through the 1858 Medical Registration Act and subsequent reforming legislation which formalised the power relationship between health groups, including the marginality of CAM. This initial legislation came about as a result of the lobby for a unified profession by the previously fragmented body of apothecaries, surgeons and high-status physicians, led by the Provincial Medical and Surgical Association that later became the British Medical Association – as science came to the fore with the Enlightenment and the demand for health care rose from the middle classes with the industrial revolution (Waddington 1984). The successful campaign to professionalise medicine was thereafter increasingly sustained by state underwriting through first the 1911 National Health Insurance Act and then the 1946 National Health Service Act – facilitated by the so-called ‘medical-Ministry alliance’, based on collusion between the medical profession and the Department of Health. This informal, but embedded, structural arrangement ensured that, amongst other things, the scope of CAM practice was limited to certain conditions through legislation enacted in the period leading up to the Second World War – with areas like diabetes, epilepsy and glaucoma excluded from claims to treatment by its practitioners (Larkin 1995).
The run-up, and aftermath, to the 1858 Medical Registration Act led to attacks by what was initially an emerging all-male medical profession on rival health groups as incompetent ‘quacks’ who were a threat to the public, through the media – including mainstream medical organs such as the Provincial Medical and Surgical Journal and the Lancet (Saks 1995). Such increasingly marginalised practitioners, many of whom were to become CAM practitioners, could still practise under the Common Law outside the publicly funded sector – albeit without the state sanctioned titles of medicine and/or that of the increasing range of other orthodox professions. However, largely as a result of being under siege from the medical profession, the numbers of CAM therapists in operation were significantly driven down in the predominant private domain in which they practised. Medical dominance, even with greater gender differentiation in the profession (Witz 1992), was further reinforced from a neo-Weberian perspective with its ever wider state market shelter, growing orthodox paradigmatic unity around biomedicine, the development of a range of predominantly female subordinated orthodox health professions like nursing and midwifery and the establishment of the even more privileged profession of medicine in terms of income, status and power (Saks 2003).

The position of doctors at the pinnacle of the health pecking order in Britain was also underlined by scientific developments in medicine, such as the discovery of penicillin and the development of more advanced surgical procedures in the first half of the twentieth century (Le Fanu 2011). However, the formal process of differentiation that began in the mid-nineteenth century in Britain appears to have been primarily political rather than justifiable scientifically at that time. This was because, amongst other things, medicine in this period was mainly oriented towards the classification of diseases as opposed to their treatment; aseptic and antiseptic techniques had not been introduced into medicine at this point; anaesthesia was not typically used in surgical operations, with all the associated hazards this brought; and hospitals were still popularly seen as gateways to death (Saks 2003). It is not surprising, therefore, that it proved so difficult to pass the necessary legislation in the mid-nineteenth century establishing the British medical profession, which took seventeen bills and much Parliamentary debate to bring to fruition (Waddington 1984).

It is instructive in this light that medicine did not become professionalised until the early twentieth century in the United States. Whatever the rationale for this differential position, the growing marginality of CAM followed the rise of orthodox medicine, as in the United States. As noted earlier, in Britain – unlike the United States where there was specific state licensing – CAM practitioners retained the right to practise under the Common Law, but otherwise had no real state legitimacy. In this sense, CAM therapists worked within the framework of a de facto medical monopoly rather than the de jure monopoly by physicians that existed in the United States in neo-Weberian terms (Berlant 1975). In addition, medical ethics in both countries continued to restrict collaboration between medical and CAM practitioners, which only took place under the potential threat of orthodox doctors being struck off as a result of such relationships. There were also intensified attacks in medical journals like the British Medical Journal on deviant CAM practitioners in the profession and informal medical colleague controls such as career blockages of medical practitioners using CAM, as well as the stifling of incipient efforts of specific CAM groups of therapists to professionalise – not least the osteopaths in the 1930s (Larkin 1995). This action against competitors who threatened the increasingly powerful leaders of the medical profession helped to bring about a fall in the use of CAM in Britain – even on a self-help basis – by the mid-twentieth century (Saks 2005a). This, however, was a prelude to the growing professionalisation of CAM that was to follow.
III The professionalisation of CAM

Despite this low point of usage in its comparatively short history, there was growing public demand for CAM from the late 1960s and early 1970s in Britain, as well as in the United States. This was inspired by the development of a counter culture on both sides of the Atlantic, which was associated with the search for alternative lifestyles, including through fashion, mysticism and hallucinogenic drugs (Roszak 1970). The specifically medical counter culture was based on, amongst other things, increasing awareness of the limits to medicine linked to its sometimes restricted efficacy and effectiveness; the focus on technocratic solutions to medical problems; the not always helpful extension through medicine of sick life; the increasing availability of a wide range of attractive medical alternatives; a desire to go beyond medical depersonalisation and disempowerment; and a drive by consumers to exercise greater control over their own health care (Saks 2000a). The development of this counter culture provided a spur to the resurgence of interest in CAM in Britain as highlighted by its ever increasing self-help use. More than this, by the beginning of the new millennium, some one-seventh of the population were visiting CAM practitioners each year, more than 60,000 CAM practitioners were in existence and CAM was increasingly employed in the National Health Service by medical and non-medical practitioners alike (Saks 2003).

These trends are an important background to the professionalisation of CAM in Britain in neo-Weberian terms. The increased professionalisation of CAM was prompted by the changing balance of power between orthodox medicine and CAM in this country – paralleling similar shifts in the United States. For the first time, there were strong political pressures for doctors and other orthodox health practitioners to incorporate CAM from a professional interest viewpoint, with the increasing popularity of CAM and rising disaffection with orthodox medicine. Indeed, by the 1980s more than three-quarters of the population wanted more established forms of CAM to be available in the National Health Service – and with the reduction in stigma associated with CAM, many orthodox practitioners, from general practitioners to physiotherapists, began to take up private practice outside the National Health Service (Saks 1992a). The General Medical Council also relaxed its prescriptive ethical codes on referrals to CAM practitioners around this time. This shift was fuelled by the greater receptivity of government to the professionalisation of CAM – driven in part by increased political lobbying for CAM, not least through influential figures such as Prince Charles and the All-Party Parliamentary Group for Complementary and Alternative Medicine (Saks 2005a).

This is not to say that medical opposition to CAM was dropped at this time. There were still accusations in the medical journals condemning CAM for its irrationality and lack of safety (Saks 1995) – as well as its comparative lack of efficacy, particularly in the context of developments in orthodox medicine by the turn of the twenty-first century in such areas as cataract surgery and hip replacements (Le Fanu 2011). The negative approach by orthodox medicine towards CAM was most fully exemplified by the report on alternative therapy by the British Medical Association (1986). This lauded the march of scientific medical progress, before linking CAM therapies with superstition and witchcraft. However, signs of the changing climate towards CAM were epitomised by the more favourable report on this area by the British Medical Association (1993) in which the discussion focused less on the ‘alternative’ therapies that threatened the interests of many of its members and more on ‘complementary’ therapies, calling for a more medicalised CAM curriculum including anatomy and physiology. One of the fundamental obstacles to progress in terms of the exercise of power, though, remained that of the extremely low state medical research funding of CAM and its marginality in the undergraduate medical curriculum. This began to change, however, with the publication of the field breaking report...
of the House of Lords Select Committee on Science and Technology (2000) on CAM, which took a positive stance on increasing research and practice in selected CAM therapies, particularly where there was sufficient evidence for their operation and robust self-regulatory mechanisms – a position now underpinned by a General Medical Council requirement to teach undergraduate medical students about CAM.

Largely as a consequence of this shifting political context, there has been a growing move to professionalise CAM in Britain. Certainly, as discussed further in this volume, CAM practitioners have increasingly based their work on a greater amount of formal education and training to enhance their expertise, along with the development of stringent ethical frameworks for practice. In line with this, ever more groups of CAM therapists have introduced voluntary self-regulation with its associated professionalising accoutrements (Saks 2003). Groups of non-medical acupuncturists and homoeopaths are illustrative cases in point. The former overcame the many previous organisational splits in acupuncture by founding in 1980 the British Acupuncture Council as a voluntary registration body, followed later by the British Acupuncture Accreditation Board, which together set minimum educational and ethical standards. Similarly, while homoeopathy has not been as unified in the contemporary context as acupuncture, the Society of Homoeopaths was established in 1981 with a voluntary register, a code of ethics, a degree-level educational programme and related accreditation arrangements – thereby progressing professionalisation in this parallel CAM field.

The osteopaths and chiropractors, moreover, went one step further in moving beyond some of their own internal divisions by putting in place more developed legally based mechanisms of exclusionary closure in Britain through private member’s bills (Saks 1999). More specifically, in 1993, the Osteopaths Act established the General Osteopathic Council, with the main function of upholding a statutory register underpinned by educational and ethical standards and providing legal protection of title. In 1994, the Chiropractors Act laid the foundation for the introduction of the General Chiropractic Council based on statutory regulation with its own standards of education and practice. It is interesting that, of all the CAM therapies, these professionalised groups are the most male dominated in a CAM environment where women are in the large majority. It should be noted, though, that there are restrictions on their legal monopolies – not least because state underwriting does not provide the privileged access for osteopaths and chiropractors to National Health Service practice that it does for more orthodox health professions. Against this, as noted previously, some qualified health professionals have themselves been delivering certain types of CAM because of the attractions it offers from a professional interest perspective at particular stages in the career ladder – in providing additional opportunities to engage in both state and private practice (Saks 2003).

Nonetheless, until recently, CAM therapists in Britain have generally been very reluctant to professionalise as they move from the cottage stage of their development based on apprenticeships and other informal means of skill acquisition (Cant and Sharma 1999). This is highlighted by the considerable delay that has occurred in Britain in forming voluntary and statutory regulatory organisations in CAM in modern times, not least compared to the United States (Saks 2000b). There also remain many outlying individual CAM therapists who do not wish to join professional bodies, even in currently rapidly professionalising CAM areas. In addition, some CAM practitioners continue to resist consolidated professionalisation in their specific fields, such as aromatherapists and crystal therapists. This is partly explained by the value placed on independence by CAM practitioners who often variously work in private practice, operate outside the National Health Service, dislike bureaucracy and hierarchy, regard individualism as sacrosanct, see a free spirit as essential to practice, hold egalitarian philosophies and do not tend to collaborate either within or across disciplines (see, for example, Saks 1997).
The term ‘herding cats’ has sometimes been applied to CAM therapists as their individualistic approach – together with factional divisions within their ranks – has served to undermine their unity and collective power in the politics of professionalisation. However, the main reason for the limits to CAM professionalisation from a neo-Weberian approach is the impact of wider systems of power. This includes the negative response to the resurgence of CAM from orthodox health practitioner groups based on professional self-interests because of the challenge that it poses through competing philosophies and practices to their income, status and power (Saks 2006). This is well illustrated by acupuncture, which in its traditional form as a panacea involves needling points on meridians to regulate the flow of yin and yang – thereby philosophically existing completely outside the realm of orthodox biomedicine (Saks 1992b). The limitations also relate to the initial rejection by government of specific CAM therapy interest in gaining professional standing without a unified approach across all the diverse CAM approaches, which was never likely to happen (Sharma 1995). Finally, the pressures bought by other interest groups against the acceptance of CAM cannot be ignored – most notably, by the pharmaceutical industry, with which there are clear interest-based CAM conflicts (Goldacre 2013), notwithstanding the increasing provision of mass-produced over-the-counter CAM remedies. This discussion leads neatly on to the consideration of the question of the future of CAM professionalisation in Britain.

IV The future of the professionalisation of CAM

In assessing the future of CAM professionalisation in Britain, it is very important to understand not just power relationships, but the benefits and costs of such a development to the public and practitioners alike. In gauging these, the position is not entirely straightforward because, as has been seen, there are different forms of professionalisation of CAM, such as voluntary and statutory regulation, which may be differentially regarded in terms of both the interests of practitioners and the public good. The view that is taken here also depends on the theoretical approach of the enquirer. This was explored earlier in the chapter in outlining the different sociological theories of professions which can run in opposite directions in relation to the professionalisation of CAM as they start out from positive or negative views of the professions. In addition, what is of benefit or cost to the CAM groups concerned may not always serve the interests of their clients and/or the wider public – although it should not be assumed that professional interests and the public interest necessarily conflict, as there is also the potential for them to coalesce (Saks 1995).

Having said this, the benefits to the public and practitioners of the professionalisation of CAM in Britain may variously include, for example, the possession of a stronger educational base, centred on certified knowledge and expertise; a greater commitment to evidence-based practice; the existence of codes of ethics protecting the public; the improved security of the position of those engaged in practising CAM therapies; and the enhanced income, status and power of CAM practitioners. There are also potential downsides in terms of the costs of CAM professionalisation, like increased social distancing from the client; constraints on the scope of practice in an era of specialisation; closed shop self-regulation giving rise to the operation of self-interested professional tribalism; silo-based professional barriers to multi-disciplinary and integrated working; and more limited client accountability and responsiveness (Saks 2003). Overall, though, the benefits may outweigh the costs for at least some CAM therapies – depending on the hazards to clients that exist in particular CAM fields.

In this light, it is perhaps not surprising that, although in the past there have been obstacles to the professionalisation of CAM, this is now becoming more of a direction in Britain. This
may seem perverse given recent media attacks on health and social care professions, including orthodox medical practitioners, in the wake of scandals involving those found guilty of abusive behaviour towards patients – from the case of Dr Harold Shipman, the serial-killing general practitioner who was convicted through the courts of disposing of over 200 of his patients (Allsop and Saks 2002), to the more recent case of the staff at the Mid Staffordshire NHS Foundation Trust who neglected the most basic elements of patient care (Francis Inquiry 2013). However, these dilemmas related to the health professions have increasingly been addressed at a wider level by government – not least through the White Paper on Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century (Department of Health 2007). The reforms highlighted here covered such areas as assuring the independence of regulatory bodies; ensuring continuous fitness to practise; and addressing new roles and emerging professions. Pleasingly, they have now largely been implemented and considerably enhance the protection of the public – even if there is clearly some way to go in policing health and social care provision at a professional and institutional level (Law Commission, Scottish Law Commission and Northern Ireland Law Commission 2012 and 2014 – see further McHale, this volume).

There were proposals in the White Paper on Trust, Assurance and Safety specifically relating to CAM as a professionalising area. These were primarily aimed at ensuring a system of regulation proportionate to the risks and benefits involved and providing statutory regulation for certain groups such as psychotherapists and counsellors (Department of Health 2007). In this respect, the White Paper also led to a CAM Steering Group being established to explore the regulation of acupuncture, herbal medicine and traditional Chinese medicine. This reported to ministers in 2008 on the statutory regulation of these groups – and prompted a consultation with key stakeholders, the results of which were fed back in 2011. This showed that most respondents preferred statutory to voluntary regulation to protect the public in these fields and to enhance practice quality. The future prospects for the further professionalisation of CAM in Britain, though, are not strong. Even acupuncture, for which statutory regulation has long been lobbied and which has one of the strongest systems of voluntary regulation (Saks 2005b), does not look like it will be allowed to have statutory regulation at present as it is not seen as such a great threat to the health of the public (Hansard 2011).

V Conclusion

The situation in relation to the professionalisation of CAM in Britain has been restricted by recently renewed attacks on CAM as non-scientific and the reluctance of some orthodox scientists to give such therapies political legitimacy – when what may be required is a more flexible, but no less rigorous, methodological approach going beyond the longstanding biomedical gold standard of the randomised controlled trial in appraising different therapeutic approaches in a pluralist society (Callahan 2002). This, however, has not prevented CAM from gaining professional standing in neo-Weberian terms in Britain and elsewhere in the Western world – even if the Anglo-American self-regulatory professional model is not so prevalent in continental Europe (Collins 1990). In countries in the latter area, a model more closely aligned to the growth of the state and state bureaucracies based on government regulated training and examination tends to prevail (Svensson and Evetts 2010). However, the trends are still unmistakeable – even if the form that the professionalisation of CAM takes necessarily varies widely. In the United States, for example, there has been state-by-state licensure of therapies like osteopathy and chiropractic, which in these specific cases interestingly preceded their statutory regulation as professions in Britain. In France, meanwhile, certain CAM therapies like acupuncture and homoeopathy have
long been absorbed exclusively into the practice of the medical profession, backed with the force of law against other orthodox health professionals and non-orthodox CAM practitioners (Saks 2003).

A key question that therefore arises in conclusion is what the most appropriate form of professional regulation may be in particular societies and in relation to which specific CAM therapies—given, as was seen at the outset of this chapter, the great diversity of the constituent elements of CAM. What should, for instance, be the balance between voluntary and statutory regulation of CAM? What rights relative to orthodox medicine should exist for CAM practitioners in relation to these modes of regulation? Should all CAM therapies be so professionalised—and where should any limits be drawn? How far should the practice of CAM be restricted to orthodox medical or allied health professionals? And how much discretion should be given to the public in terms of safety to engage with CAM through self-help rather than practitioner delivery? These issues all require further debate politically from the standpoint of consumers, both in Britain and internationally. However, from a sociological viewpoint, the form that CAM takes in the future seems likely to continue to be based on the prevalent configurations of power and interests discussed. Nonetheless, sociological knowledge of the operation of these power structures by groups such as users, CAM practitioners and orthodox health professionals may usefully feed into the debate—along with the contributions of disciplines other than sociology, from public health specialists to health economists. This will help to promote a positive resolution of the issues raised in the public interest in terms of future policy on professionalisation in CAM in Britain and beyond.

References
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