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Redefining Medicine:
Boundary Work and Legitimating Claims
Among Acupuncturists and Physicians

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An abstract of
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Abstract

Redefining Medicine:
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By Charity E. Crabtree

In this study I interview physicians, licensed acupuncturists, and medical acupuncturists (physicians who are licensed to practice acupuncture as well) in order to clarify the types of boundary work and legitimating claims used to maintain distinctions between acupuncture and conventional medicine in an increasingly "diverse" medical field. All practitioners use social and symbolic boundary work to some extent; where social boundaries are weak, often symbolic boundaries become increasingly important to physicians trying to maintain professional dominance. They are also important to acupuncturists concerned with highlighting their distinctiveness from this institutionalized (and seemingly flawed or inadequate) healing modality. The fluid nature of these types of boundaries hints at the legitimation process undergone by exotic or unusual cultural elements in our society. Moral and cognitive legitimacy are valuable tools for overcoming social boundaries, and claims of such are vehemently made (and challenged) by advocates (and adversaries). As more patients are seeking out alternative treatments, results indicate that physicians tolerate and even welcome alternative perspectives but use symbolic means of distinguishing between good medicine and false hopes. Evidence also indicates that acupuncturists have adapted explanations of acupuncture to fit the current medical landscape, as a result contributing to an understanding of acupuncture as a type of medicine that has the potential for filling in the "gaps" left by conventional forms. Results suggest that the success of other types of healing in entering the medical field depends on collecting a body of scientific research supporting the claims of the alternative healers and developing explanations of their medicines that make sense in the current medical landscape, as well as making an argument that they are able to do things conventional medicines cannot.

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Acknowledgements and Dedication

Words cannot express the gratitude I feel for my dissertation chair and advisor John Boli. His support has made this dissertation possible, and his practical and theoretical wisdom, which he has so generously shared with me over the years, have helped make it a dissertation I can be proud of. I owe thanks to the rest of my committee: Matthew Archibald patiently listened to hours of me gathering my thoughts on the subject, and his enthusiasm about the project inspired me to devote to it the extremely large amount of myself necessary for its completion; Tracy Scott provided invaluable methods advice and consistent encouragement; and Michael McQuaide provided support for this project and expressed interest in the topic that was a constant source of encouragement.

I am also proud to acknowledge the strength and encouragement provided by my friends and family. My friends have supported me when I felt incapable, comforted me when I felt discouraged, and cheered and distracted me when I felt overwhelmed. I could not have done it without them. I must also specifically mention my friends Heather McIver and David Hobbs (both L.Ac.). Long talks with each of them inspired me to turn my research interests in the direction of medical sociology and undoubtedly nurtured the seeds of my theoretical curiosity.

Finally, my family's pride has motivated me to achieve more than I thought was possible, and their excitement about my somewhat unconventional life choices has allowed me to feel fulfilled while doing so. My mother, Talula Cartwright, has always graciously allowed me to find my own path and enthusiastically supported me every step of the way. Without her encouragement and example I certainly would have settled for much less in my life. For that reason I am eternally grateful, and with my whole heart and soul and mind, I dedicate this dissertation to her.

To my mother,
Talula Cartwright, Ed.D.

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Chapter One: Introduction

Biomedicine is a form of healthcare based on the philosophy that illness or disease is caused by factors that interfere with the normal biological functioning of the body. Further, each specific illness is treated with the same treatment regimen. This form of Western medicine "occupies a dominant, often exclusive monopoly over legitimate medical care in many societies" (Shuval and Mizrachi 2004: 675). As such, it is taught and practiced throughout established institutions, such as medical schools and hospitals. Because it holds a dominant position among medical institutions, it is considered "conventional medicine" in the United States.

The processes by which conventional medical actors have formed exclusive and privileged professions and claimed the dominant position in healthcare institutions have frequently been the subject of study among scholars of organizations and professions. This is an especially fruitful time to examine the field in which these struggles are taking place because the medical field is currently experiencing growth and diversification. Patients are taking the initiative and increasingly incorporating alternative and complementary therapies in their own treatment. Physicians are increasingly involved with these other therapies and practitioners, in their patients' as well as their own interests. By opening their minds to these alternatives, they are able to satisfy their patients and improve their own practice, while maintaining a degree of control over the institutional field they have helped shape; they do this by insisting that newcomers prove themselves through testing by standards that conventional healthcare providers have adopted.

Healthcare providers undergo socialization processes as part of their education or training, which in turn shapes many aspects of their professional life (Beagan 2000,

Becker 1977). For one, it might potentially lead to differences in the extent to which practitioners open their minds and the approach they take toward competitors. Those who are the most open-minded may choose to be integrative practitioners. Andrew Weil, a widely published integrative physician, explains that integrative medicine requires that a physician practice with a complementary or alternative medicine (CAM) provider in the same space (see Rees and Weil 2001). Rees and Weil (2001) further explain integrative medicine as "practicing medicine in a way that selectively incorporates elements of complementary and alternative medicine into comprehensive treatment plans alongside solidly orthodox methods of diagnosis and treatment" (2001: 119). In Weil's Program in Integrative Medicine at the University of Arizona, physicians are taught how to integrate selected CAM therapies into their own practices.

The differences in how physicians and acupuncturists perceive their practices and how they perceive the practices of others mirrors the concept of collective identity formation frequently used in theories about social movements. A collective identity is a shared sense of belonging, or group identity, that facilitates individual action on behalf of the group (Polletta and Jasper 2001). This dissertation focuses on two key processes in the formation and maintenance of the collective identities of healthcare providers: legitimating claims or narratives, and boundary work, which is both social and symbolic (Polletta and Jasper 2001, Hsu 2001, Lamont and Molnár 2002). I examine the ways these two important types of activities are carried out by integrative and non-integrative healthcare practitioners of biomedicine conventional medicine and acupuncture.

Lamont and Molnár (2002) emphasize the ongoing nature of social and symbolic boundary work, both of which are evident among healthcare providers. Social boundaries, or points of unequal access to resources and opportunities, are maintained

between the occupational groups, as the organizations and professionalization literatures lead us to expect; acupuncturists and biomedical physicians maintain separate practices and specialization claims in attempting to define, claim, or protect professional dominance (Freidson 1986) or jurisdictional control (Abbott 1988). As the most institutionally dominant and legitimate group, conventional physicians attempt to maintain their advantage in this area.

Scholars argue that symbolic boundaries allow conventional medicine to maintain epistemic control over healthcare, despite increasingly permeable social boundaries (Shuval and Mizrachi 2004, Hess 2004). Integrative practice requires that social boundaries be permeable, since integrative practitioners are healthcare practitioners that work together in the same physical or professional spaces. Putting a greater emphasis on symbolic boundaries by conventional physicians is a way of maintaining professional dominance and jurisdictional control (see Gieryn 1983). Symbolic boundary work consists of categorizing people and practices, such as acupuncture or conventional medicine, as having certain characteristics (e.g. logical, dangerous, unscientific, innovative); if conventional medical institutions can convincingly hold CAM practices as dangerous or ineffective, they would be able to maintain a professional advantage.

Boundary work starts early, is formalized in places like educational institutions, and is continually undertaken in interactions with others. Training in conventional medicine, which has a long history of exclusivity and esoteric specialty, helps maintain these symbolic boundaries. As conventional medical professionals carry these boundaries into their practices, they can potentially help protect the jurisdictional legitimacy of their medicine by portraying their own practices as helpful and effective,

and others as flawed. Training in acupuncture may lead to more specialized collective identities, based less on protecting exclusive knowledge and more on their shared experiences in a society of healthcare institutions unfavorable to alternatives that would encroach on their professional dominance.

This study seeks to specify the extent to which physicians and acupuncturists engage in boundary work and make legitimating claims. By interviewing integrative and non-integrative physicians and acupuncturists, I attempt to elucidate a link between individual sense-making activity (ways of understanding reality) and narrative legitimation processes (ways of explaining this reality) when actors are experiencing institutional change, such as is occurring presently in medical institutions in the United States. How do individual actors make sense of the changes occurring around them in their field, and how might these sense-making activities and claims be related to attempts to maintain, strengthen, or limit boundaries between larger professional groups that are themselves undergoing massive changes? These are the central questions inspiring this study.

Enchanting Science

Sociologist Max Weber argued that the world has become disenchanted, a premise that continues to influence sociological arguments to this day. "Disenchantment" refers to the process by which religion is supplanted by scientific explanations to account for aspects of the natural world such as the sunrise, the weather, or the origins of humankind. The answers to the "big questions" are found not in the efforts of a superior divine power but in natural forces that, unlike the divinity, can be rationally explained and understood. Belief that is "enchanted" gives way to knowledge

that is "scientific." This rationalization process is central to Weber's sociology. He argues that the process of disenchantment, and the rationalization process as a whole, is twofold, whereby magical explanations decrease in number, while rational explanations flourish and are increasingly systematized and standardized (Weber 1946: 51). As scientific explanations become increasingly complex, some argue that the world has actually become *re*-enchanted; as a social whole, we have come to rely as heavily on scientific explanations that we no longer understand as previous social groups relied on religious processes they could not explain (see Johnson 1995, Nietzsche [1887] 1998).

Over the past several hundred years, biomedicine has been rationalized along Weberian lines (Starr 1982, Whorton 2002). Biomedicine and the functioning of the body itself have undergone a long process of disenchantment and re-enchantment; while the body is no longer seen primarily as a mysterious creation of the divine, scientific explanations of anatomy and physiology are not widely understood, either. The biomedical way of thinking about health and illness in the United States has not always been taken for granted. Rather, the actors who have advocated this system of thought actively positioned themselves in such a way as to achieve and maintain this taken-for-grantedness. The struggle for legitimacy undertaken and won by biomedicine practitioners was a long and complicated one, involving trade associations, federal regulations, and medical education and certification standardization. The result is that biomedicine has become highly rationalized and esoteric.

Medical rationalization has not been confined to conventional biomedicine. "Traditional Chinese Medicine" (TCM) is also highly rationalized, thanks in large part to pressure by the Chinese government led by Mao Tse-Tung (Quah 2003, Hare 1993). Before Mao, the Republican government had attempted to closely regulate Chinese

medicine, and the push towards "Western" medicine was felt very strongly by practitioners of traditional medicine. When the Communist Party took power in 1949, it more actively celebrated these traditional forms of Chinese medicine, and in doing so, contributed to its standardization (Quah 2003).

Biomedical physicians have worked hard to attain and maintain their own legitimacy and authority (Starr 1982). Opening their arms to alternative treatments provides these alternative treatments and alternative practitioners with that much more trust on the part of patients/consumers who have come to have faith in conventional biomedicine. However, physicians have asked much in return. Namely, physicians frequently require conformity to biomedical understandings of sickness and treatment. Without this conformity, acupuncture really is just a "quack" science, and results achieved through treatment are likely to be seen as incidental and arbitrary. The development of Medical Acupuncture allowed practitioners to claim many of the successes of acupuncture without the "quackery" of TCM's five elements (Wood, Water, Metal, Earth, Fire) or the spiritual requirement of historical Chinese medicine that the patient live in accordance with the Tao. Thus, a more rationalized version of TCM has entered the realm of biomedical possibility (and legitimacy) through the advocacy and practice of Medical Acupuncture. One important advocacy group has been the American Academy of Medical Acupuncture, a physician-only group founded in 1987 (American Academy of Medical Acupuncture).

Legitimating Science

Recent work on legitimacy (Johnson et al. 2006) describes it as a four-stage process: local innovation, or use on a small scale, is followed by local-level validation, or

small-scale acceptance of the effectiveness or utility of the innovation. This local-level validation leads to diffusion, or use on a larger scale, which may eventually result in general validation. Once general validation is achieved, the practice assumes a taken-for-granted quality, in both cognitive and moral dimensions. Cognitively, it is considered a valid aspect of social reality, one that makes sense. Moral legitimation implies that the practice is assumed to be good for people, in this case, patients. In the case of acupuncture, it must first be seen as a valid option when pursuing healthcare treatment; it must be available and legal. In order to have moral legitimacy, acupuncture must also seem the right form of healthcare treatment to provide healing or symptomatic relief to patients.

When physicians begin talking among themselves about acupuncture, we see that acupuncture has been successfully navigating the legitimacy process outlined by Johnson et al (2006). Acupuncture has been practiced and found useful on local levels, not only in China and elsewhere in Asia, but also in the West, where biomedicine has already secured institutional legitimacy. Further, the large number of books about acupuncture aimed at lay and medical audiences alike are evidence of its diffusion, wherein more people are beginning to learn about acupuncture, both patients and biomedical physicians. What remains in the legitimation process is the general validation of acupuncture throughout legitimate biomedical institutions. How far general validation proceeds depends largely on the actions and opinions of institutionally legitimate actors, such as physicians, and the responses of extant medical institutions, such as insurance companies and hospitals (see Ruggie 2004).

Bounding Science

Standardizing rationalization and legitimation processes require and result in the delineation of boundaries. In the health care field, boundary work influences the way practitioners understand their own identities. Specifically, boundary work results in understandings of one's own professional identity that are dependent upon the occupation and associated task performance and requirements (Abbott 1988), which themselves are defined in terms of uniqueness, desirability, special effectiveness, and so on.

The process of boundary-related identity formation is also similar to the concept of collective identity put forth in theories of social movements. Collective identity that is maintained within social movement organizations is a crucial way of securing the participation of individual activists. Theorists posit that successful collective identification with the group or cause motivates social movement activists to continue work that often fails to produce concrete benefits (Taylor 1989, Taylor and Whittier 1992, 1995). In this case, to continue to practice or advocate a certain form of medicine, the practitioner must identify with the particular health care method.

Another important aspect of collective identity is its boundary-delineating function. Taylor and Whittier (1995: 173) describe collective identity as a multi-part process consisting of constructing group boundaries that define insiders vis-à-vis outsiders, constructing and maintaining interpretive frameworks through which to understand the group's struggle, and "*the politicization of everyday life* through the use of symbols and everyday actions to resist and restructure existing systems of domination" (emphasis in original). In this sense, different types of health care practitioners come to see themselves as different from and in opposition to other types.

In social movement theories, boundaries delineate activists from non-activists, while legitimating claims justify the need for change (in the interest of the needs and with the support of the public, for example) or the lack thereof (by actors opposed to the social movement). In organization theories, boundaries delineate task-specific groups and legitimating claims present an organization as effective or necessary.

Focus of the Study

This study is driven by the following general research question:

> ***In what ways do integrative and non-integrative healthcare practitioners practice social and symbolic boundary work and use legitimating claims?***

I used semi-structured, in-depth interviews of integrative and non-integrative acupuncturists and physicians to examine the types of boundaries and legitimating claims that are created by competing and cooperating actors in the healthcare field.

Indicators of boundary work include feelings of similarity with members of their groups and distinctiveness from other groups. I sought information about this issue by asking respondents to explain their perceptions of different approaches to healthcare, describe how acupuncture differs from biomedicine and from other CAMs, and explain how integrative medicine differs from other approaches.

In my interviews, I sought evidence of both cognitive legitimation (validity) and moral legitimation (usefulness). Cognitive legitimation indicates that acupuncture or integrative medicine works; in order to make sense of how and why this is the case, participants might claim compatibility with conventional medicine or reference the historical background of acupuncture. Moral legitimation includes arguments about the weaknesses of other paradigms, thereby presenting a picture of one's own paradigm as the most suitable for helping patients. Another moral legitimation argument describes

acupuncture as either autonomous and sufficient in itself, or (as delegitimation) in need of supervision by conventional medicine and its institutions.

I expected that integrative and non-integrative acupuncturists and physicians would use different sorts of legitimating claims, and perform different types of boundary work. I also expected that the different types of professionals would differ in the extent to which they attempted to distinguish their healing modality from or compare it to other modalities. In my hypotheses, I propose types of boundary work and legitimating claims that I think the four types of professionals would be likely to use.

Overview of the Dissertation

I begin by briefly reviewing the history of Chinese medicine in China, the history of biomedicine in the United States, and the complicated relationship of the two systems of medicine over the past century and more. I then move to a more detailed review of sociological theory relevant to my study in Chapter Three. In Chapter Four, I present my research model and hypotheses and detail the methods by which I collected and analyzed data.

The central concern of this study is delineating the ways in which integrative and non-integrative healthcare practitioners practice social and symbolic boundary work and use legitimating claims. I present detailed findings relative to the hypotheses regarding this central concern in Chapters 5 and 6, on boundary work and legitimating claims respectively. After concluding with a discussion of the results, I will then revisit the question of medicine's enchantment.

I will show that all practitioners use social and symbolic boundary work, and that where social boundaries are weak, often symbolic boundaries become increasingly

important to physicians trying to maintain professional dominance. They are also important to acupuncturists concerned with highlighting their distinctiveness from this institutionalized (and seemingly flawed or inadequate) healing modality. The fluid nature of these types of boundaries hints at the legitimation process undergone by exotic or unusual cultural elements in our society. Moral and cognitive legitimacy are valuable tools for overcoming social boundaries, and claims of such are vehemently made (and challenged) by advocates (and adversaries).

In addition to providing evidence of this process, this dissertation expands our understandings of concepts including include collective identity, professionalization, legitimation, boundaries, and boundary work. These concepts are applicable to sociological theories of organizations, culture, and social movements, are quite far-reaching. This study also aids in a deeper understanding of the different forms taken by boundaries and gives some clues as to why integrative medicine is not more common. Finally, this study illustrates how legitimating claims are used strategically by healthcare professionals seeking to move their healing modality into the mainstream, and how they balance these with attempts to distinguish their healing modality from extant mainstream modalities.

Chapter Two: The Science and Culture of Biomedicine and Acupuncture

> The ideology of Chinese medicine immediately captivated me by its stark contrast to the perspective of Western medical science. I had never been comfortable thinking of myself in my father's language of electrolytes and blood-gas ratios, a collection of quantities and statistics. The Chinese medical vocabulary contained metaphors from nature like *Wood, Fire, Earth, Metal,* and *Water, Heat, Wind, and Cold*. This cosmological description of human process confirmed what I knew intuitively to be so—that what moves the world outside moves within me—that subject and object are two aspects of one phenomenal world. As peculiarly outside my cultural context as it was, Chinese medicine felt familiar. What enticed me even more than my sense of continuity with family tradition [in conventional medicine] was the affinity I felt with its concepts, and I wondered if the ancient wisdom embedded within its construction of reality could untangle some of our modern predicaments. (Harriet Beinfield in Beinfield and Korngold 1991: 4).

Biomedicine, or conventional medicine, is "an elaborate system of specialized knowledge, technical procedures, and rules of behavior" (Starr 1982: 3). It is thus rationalized in the Weberian sense as a systematic and ordered structure that explains health and illness in seemingly "real" or "natural," rather than magical, terms (Weber 1946). Despite its apparent naturalness or inevitability, Starr contends, modern medicine includes understandings of illness, health, and healing that are shaped by the culture in which it has developed. Generalizing this view, we should expect that all medical systems of thought are similarly reflective of their cultural context.

The history of "medicine" in the United States is a long and complicated story of intense competition among advocates of several bodies of knowledge and practices. Thus, the hard-won success of biomedicine is something biomedical practitioners and institutions often try whole-heartedly to protect. In this chapter, I will begin with a brief review of the history of Chinese medicine in China, before outlining the development of conventional medicine (i. e., the transformation of biomedicine into conventional medicine). I will then move to a discussion of the interactions of Western and Eastern

medicines, and Traditional Chinese Medicine in particular. The history of Western medicine below draws from Starr (1982) and unless otherwise noted, comes from this source.

In trying to understand the move of a previously marginal medicine such as acupuncture into the territory occupied by conventional medicine, it is important to consider the history of both medicines. Doing so makes it possible to understand how and why the relationship between the two systems of thought and their practitioners has developed as it has. This background will set the stage for the theoretical background I lay out in the next chapter, and for the hypotheses I subsequently propose.

THE TRADITION OF "TRADITIONAL CHINESE MEDICINE"

The celebration of traditional forms of Chinese medicine instigated by the Communist Party after its rise to power in 1949 initiated a rationalization process that standardized Chinese medicine in several ways (Quah 2003, Hare 1993). First, the organizations responsible for teaching what came to be formally known as "Traditional Chinese Medicine" were standardized. In Beijing in 1955, the Academy of Traditional Chinese Medicine was established, as a merger of four organizations: the Chinese Pharmaceutical Institute of the Central Academy of Public Health, the Acupuncture-Moxibustion Experimental Institute, the School for the Advanced Study of Traditional Chinese Medicine, and the North China Hospital (Quah 2003: 2004). In addition, policy directives pressured practitioners to raise the standards of care. Finally, the government became involved in the publication of medical knowledge. By the early 1980s, the government was publishing *The Journal of Traditional Chinese Medicine* and numerous textbooks, such as *Modern Chinese Medicine* and *Chinese Surgery* (Quah 2003). Mao's

original vision was to merge the best of Chinese medicine with the best of "Western" biomedicine, but Quah, among others, argue that economic shifts in health care policy in the 1990s have prevented true integration from occurring, since the emphasis shifted to biomedicine and away from more traditional medicines. As a result, research on traditional medicines became a lower priority as well, which further hindered full integration (Quah 2003: 2004-2005).

Despite this, Traditional Chinese Medicine remains a rationalized approach to healthcare, and this approach forms the basis of the training received by most acupuncturists in the United States. As part of their training in acupuncture, many students of "Oriental Medicine" (as it is commonly called in the United States) are taught other aspects of TCM as well, including medicinal herbs, moxibustion (the use of heat and herbs applied on certain points in the body), and Tui Na, or Chinese massage. Kaptchuk (2000: 106) describes acupuncture as follows:

> … working with points on the surface of the body will affect what goes on inside the body, because it affects the activity of the textures that are traveling through the Meridians. Every Chinese physician must have a complete grasp of the Meridian system. Most acupuncture points relate to the Meridians, and most herbs a doctor prescribes are thought to enter one or more of the Meridian pathways.

Acupuncture theory is based on texts thousands of years old, and it has a long history in places other than China as well, such as Japan, Singapore, Vietnam, and Korea (Kaptchuk 2000: 385*n*.21, Quah 2003). The health care system that would come to be known as Traditional Chinese Medicine is derived from these ancient texts, one of the most important being *The Yellow Emperor's Canon of Internal Medicine*. This particular text was elaborated and a curriculum developed around the knowledge it contained around 610 C.E. (Huan and Rose 1999: 157). According to Huan and Rose,

between 265 and 960 C.E. medical education emerged in China, the government established an office of medicine, medical specialization developed, and the lengths of courses of study were standardized (1999: 158).

The development of standardized Chinese medical practices was a complicated process. Huan and Rose distinguish between folk medicine, practiced among rural patients, and court medicine. Folk medicine practiced by local doctors in China differs from the "official" form of acupuncture mandated or guided by the court or state (1999). Some of the most prestigious doctors only treated those within the royal court (Liu 1998). Huan and Rose (1999: 146) explain, "While traditional theories and practices have continued evolving and developing in the countryside over thousands of years, there has also been a well-organized development of the subject conducted by successive official administrations." Even at the turn of the 20th century, when there was a conscious move away from Chinese medicine towards Western ("modern") medicine, folk medicine was still practiced in the countryside (Huan and Rose 1999, Quah 2003).

Sometimes these rural practitioners were called "barefoot" doctors because many of them were farmers who originally worked barefoot in rice paddies, having been trained in basic medicine. They walked from town to town treating people without other access to medicine. As part of the Cultural Revolution, and in order to improve agriculture by way of improving the health of those in rural areas, Mao institutionalized this system. At the time there was a dramatic shortage of formally trained physicians in China, and most of these were settled in urban areas (Valentine 2005).

While Chinese medicine was looking west, the West was also looking east. In fact, European physicians traveled to China as early as the 17th century to study acupuncture and moxibustion (Barnes 2005). While small numbers of Westerners had been studying Chinese medicine in China for some time, it was not much used in the West (Barnes 2005). Historians attribute this fact largely (in the United States, at least) to action on the part of biomedical advocates to limit competition with their own approach (Whorton 2002, Liu 1998). In the early 20th century, Western (bio-)medicine began more strictly regulating itself as an industry, creating standards through which questionable aspects of the practice of medicine could be eliminated (Whorton 2002). Liu (1998: 178) attributes early public interest in alternative medical treatments such as Chinese medicine to the lack of standardization and effectiveness of "Western" medicine at the time.

Despite efforts to keep Chinese medicine illegal or marginalized, acupuncture had been in the United States for at least a hundred years by the early 1970s, when it first entered the mainstream American imagination. In the 19th century, Chinese immigrants practiced acupuncture within their own community and with some non-Asian patients. At times the latter occurred under the so-called supervision of biomedical practitioners, such as chiropractors. In addition to biomedical elitism, racism kept acupuncture illegitimate for many of these practitioners (Whorton 2002, Liu 1998, Barnes 2005). As acupuncture began professionalizing in the 1970s, however, challenges to its legitimacy took on a different tone, as I will explain below.

CONVENTIONALIZATION OF BIOMEDICINE IN THE UNITED STATES

Some theorists, such as Johnson (1995), go so far as to suggest that medicine, as a cultural product, shares similarities with religious schools of thought. In his view, science (and medical science in particular) is a form of religion, and scientific explanations are in fact magical. This magic comes from the mystery of the explanation—in Weberian terms, people become re-enchanted with the world; in Nietzschian terms, science ousts religion and positions itself as the ultimate source of truth ([1887] 1998). For this to occur, however, science must be beyond reproach, having the power to re-enchant and being worthy of worship. It is important, then, that medicine is not consciously perceived as socially constructed (and thus fallible) by the societies and cultures in which it has achieved dominance. The establishment of scientific medicine as fact and truth, rather than supposition or superstition, has occurred through a process of legitimation: the move in the public imagination from risky and experimental to safe and conventional. Once thus established, those aligned with this system of thought are deeply invested in it, and challenges are liable to be met by them rather energetically.

Biomedical practices and practitioners were able to secure and protect competitive advantages over other types of healthcare through the development or "professional sovereignty." Professionalism provides "a basis of solidarity for resisting forces that threaten the social and economic position of an occupational group" (Starr 1982: 27). Solidarity within a particular occupational group allows group members to present a united front against challengers, such as practitioners of alternative forms of medicine. In the United States, both the epistemological and market dominance of conventional medicine were secured through the standardization of training and

licensure by biomedical (or "modern medical") practitioners and the institutions in which they participate.

Forming a Profession

When physicians in the United States first began professionalizing in the 1760s, three separate "spheres of practice" co-existed, all of which were of relatively equal importance in daily life: practice by physicians, by lay healers, and within the household by the family. By the early 19th century, the "world" of so-called modern medicine had arisen, characterized by a newfound reliance on empirical evidence and a consolidation of medical authority in the hands of physicians. Previously, the authority of a person or a tradition sufficed to support claims of medical truth; in this newly established medicine, physicians' authority became based upon their relationship with empirical research, leaving little room for the authority of household and lay healers.

The prominent cultural emphasis on democracy in the United States was related to some of the popular resistance to medicine in the early years, according to Starr. Combined with the ineffectiveness of many early medical practices, the relatively secret nature of medical knowledge was also cause for skepticism. In the popular mind, medicine should work, and it should be understandable to everyone. Rather than accepting knowledge kept among the privileged and authoritative few, public sentiment at the time held that any clouding of medical truth was unnecessary at best, and at worst, a way to disguise potentially deadly pseudo-medical practices. As one newspaper suggested, a "machinery of mystery and concealment… which serves but as a cloak to ignorance and legalized murder" (*New York Evening Star*, 1833, quoted by Starr 1982: 56).

In the early 1800s, some states began licensing practitioners, driven in part by a desire to limit the "ignorance and murder" committed by unqualified practitioners, and in part by movements on the part of "regular" practitioners, who felt themselves, due to training and practice, to be above the dangerous practices and ignorance of "irregulars." The popular view at the time, however, was that licenses were obtained on the basis of who a licensee knew rather than what he knew, and the practice was suspended.

What finally established the authority of medicine was science. Specifically, developments in science were able to "establish the cultural authority of medicine by restoring a sense of its *legitimate complexity* … [by giving] rise to complexity and specialization, which then remove knowledge from the reach of lay understanding." (Starr 1982: 59). As science developed and became increasingly complex, the public gradually began to place trust in medicine; comforted by the new, legitimate scientific complexity of medicine, the public no longer felt that it was necessary to understand the complexities.

While public support swayed in favor of scientific medicine, economic factors still caused many people to rely on household remedies as much as possible. Another obstacle to physician dominance was the improvement of transportation, which allowed for more competition; no longer was a physician's dominance in a small community guaranteed, since potential patients might travel to a different practitioner. Thus, the market began to influence the development of the profession of medicine. Several problems for physician authority and dominance arose, prompting physician cooperation: 1) a sufficient number of physicians was necessary to meet the healthcare needs of the public, but too many would flood the market, so the number of available practitioners needed to be regulated; 2) physicians needed be able to control the number

and types of jobs they perform; and 3) physicians needed to ensure that they were in control of their relationship to organizations such as hospitals.

By solving these problems through a united front, physicians improved their professional group's status, wealth, and authority. These changes in medicine created an environment in which the lay public deferred to physician authority and gradually became dependent on it. Physicians and their professional groups were able to turn this authority into social, cultural, and economic gains for their members. The boundaries physicians had created between regulars and irregulars, and between physicians and home healers, all facilitated this process. However, the legitimating claims they were using soon became threatened by crisis.

LOSING FAITH IN MEDICINE, FINDING HOPE IN CAM

Even with the emergence of large-scale insurance companies and the re-organization of the medical marketplace that resulted, physicians were able to maintain their authority and the gains that accompanied it. In the 1970s, however, a shift occurred. The "crisis of healthcare" in the early 1970s (as perceived by 75% of heads of households in 1970) was a crisis of rising costs, limited accessibility, and dissatisfaction with physicians (Whorton 2002). Moral and cultural concerns about the authority of the medical professions and the safety of medical practices, along with economic and political concerns brought about by financial and organizational changes such as the corporatization and privatization of healthcare, revived and strengthened lingering doubts about the medical profession and its institutions. The problems became political when government intervention was proposed, and the problems that emerged were no longer related to the "science" of medicine.

Moral, Economic, and Political Pressure

One dramatic instance that called into question the authority and safety that had been taken for granted for decades occurred in the late 1950s and early 1960s, when inadequately tested thalidomide was prescribed for morning sickness but turned out to cause serious birth defects (Silverman 2002). Alternative-medicine practitioners seized the opportunity to raise suspicions and fears about biomedicine in the interest of improving their own position, which had been compromised by the success of biomedicine. Opponents suggested "that modern medicine was guilty of a 'presumptious expertise' that required every form of human suffering to be pressed into its narrow biomechanical construct of disease" (Whorton 2002: 245). In the 1970s, according to Whorton, "a full-scale revolt" erupted, "not just against routine prescribing of drugs and physician indifference toward patients as people but above all against the mindset of biological reductionism that fostered such attitudes" (2002: 247).

Aside from moral factors, the authority gained by physicians as a professional group, which rests on cohesiveness and organization, is vulnerable to changing economic conditions. One of the most dramatic economic changes has been the increasing role of corporations, primarily health insurance companies and hospitals, where more physicians are working, and corporations formed among physicians themselves. Physicians may lose autonomy to corporate executives and their emphasis on maximizing profits and minimizing costs (e.g., performance evaluations of revenues generated, keeping a close watch on mistakes to minimize the chances of malpractice suits).

The political response to the crisis of healthcare, as outlined by Starr, consisted of three phases of political action. First, public sentiment (and legal action) began to favor

increasing regulation of the healthcare industry and, in the interest of social welfare, healthcare came to be viewed as an entitlement. Second, the situation reached a stalemate in 1975, with declining confidence in the value of medical care, economic worries due to inflation, and the abandonment of a movement for national health insurance. Finally, toward the end of the decade, there was a turn in public opinion against liberalism, or the view of healthcare as an entitlement. After the election of Ronald Reagan as President, many of the programs enacted in the first period were overturned or abandoned. Political actors advocated a drive to return healthcare responsibility to the private sphere, and in response to rising healthcare costs and free-market ideology, pushed healthcare into a competitive "medical marketplace" (Clarke et al. 2003).

Within this medical marketplace, large-scale reforms in medical research "sought to free therapeutic evaluations from human judgment based on clinical experience and impressions" (Kaptchuk 2000: 355). As the double-blind randomized controlled trial began to grow in popularity, medical research underwent reforms to help resolve (through self-regulation) any emerging doubts about the strength of claims made by medical science. Access to this type of scientific legitimacy was limited, however, since this research method was impractical for many forms of healthcare, such as acupuncture.

Changes in Medicine: The West Looks East

In the 1970s, while healthcare in the United States was in a state of crisis, acupuncture was becoming a relatively popular alternative to conventional and increasingly problematic conventional medicine, thanks to the broad cultural and

political changes of the time. Whorton (2002: 256) explains: "The hippie ideology that bloomed in the 1960s fostered an interest in the contemplative, non-violent spiritual traditions of the Orient, while even those most repelled by the hippie lifestyle had their attention turned eastward in the early 1970s by the lifting of the Bamboo Curtain and the reopening of diplomatic relations between the United States and China." Increased interest in China, both political and cultural, led to widespread publicity of an important event in 1971. *New York Times* reporter James Reston was in Beijing in 1971 to report on the relations between the United States and China when he experienced acute appendicitis. He underwent surgery with conventional anesthesia but experienced continued pain the next night. An acupuncturist treated him and a week later an article by Reston about the experience appeared on the front page. Two months later, the Chinese Medical Association invited four doctors from the United States on a medical tour of China, where they observed patients receiving acupuncture as anesthesia for surgery on organs ranging from the ovaries to the brain (Whorton 2002).

Chinese physicians are trained in Western medicine, and at the time, those who spoke with the American doctors confessed that even they themselves did not believe acupuncture would be as successful as it was until they observed it. They were surprised to find that although not all patients were suitable candidates for pain management by acupuncture, those who were experienced a 90% success rate. When Nixon visited China in 1972, physicians traveled with him, to further observe the use of acupuncture (Whorton 2002).

Ten years earlier, German-born British medical doctor and acupuncturist Felix Mann was already convinced of the value of acupuncture, and in 1962 wrote a book aimed at a physician audience entitled *Acupuncture: The Ancient Chinese Art of Healing*.

By the early 1970s, he was writing for Western lay audiences; one notable book from 1971 was entitled *Acupuncture: Cure for Many Diseases*. The title reflects the excitement with which many Westerners viewed alternative approaches to healthcare. Aldous Huxley, whose dystopian novel *Brave New World* notably contrasts "primitives" and "modern" society, wrote the forward. The first few sentences indicate both the wonder and incredulity that often seem to accompany the discovery of acupuncture by Westerners:

> That a needle stuck into one's foot should improve the functioning of one's liver is obviously incredible. It can't be believed because, in terms of currently accepted physiological theory 'it makes no sense'. Within our system of explanation there is no reason why the needle-prick should be followed by an improvement of liver function. Therefore, we say, it can't happen.
>
> The only trouble with this argument is that, as a matter of empirical fact, it does happen. Inserted at precisely the right point, the needle in the foot regularly affects the function of the liver (in Mann 1971: *v*).

The logical solution to the problem of disbelief among Western audiences is to translate acupuncture into a language Westerners are able to understand – to *make acupuncture make sense*. Mann assures readers that the "incredible" results that acupuncture is capable of achieving are easily explained using biomedical terms; the secrets are translatable, and who better to translate them than a physician? Mann was an early supporter of acupuncture but as time passed, his support became more conditional. In fact, for the 1973 reprint of his 1962 textbook, the subtitle was changed to *The Ancient Chinese Art of Healing and How it Works Scientifically.* In fact, by 1993, in his text *Reinventing Acupuncture*, he argues that "the traditional acupuncture points are no more real than the black spots a drunkard sees in front of his eyes" (14) and further, that "the meridians of acupuncture are no more real than the meridians of geography. If someone were to get a spade and tried to dig up the Greenwich meridian, he might end

up in a lunatic asylum. Perhaps the same fate should await those doctors who believe in [acupuncture] meridians" (31).

It should be noted, however, that as early as 1971, Mann issued a strongly worded warning preceding the first chapter. This warning vividly reveals the skepticism with which acupuncture was viewed, even among those convinced of its healing potential:

> It should never be forgotten, that a knowledge of medicine is required to practise acupuncture satisfactorily: it is not the only prerequisite, but it is an important keystone. A doctor who has studied physiology and pathology, who knows the natural course of a disease, and who has during his studies and practice accumulated a wealth of clinical experience, may tackle a large variety of mild and serious diseases, for he knows what to expect if a given organ is stimulated.
>
> The numerous practitioners of acupuncture, who are not doctors, who do not know the basic principles of medicine, who often have not studied acupuncture adequately, unfortunately, all too often, achieve results commensurate with their lack of knowledge (Mann 1971: *xii*).

Although the warning indicates a certain amount of skepticism about acupuncture, the fact that a respected physician was using and praising acupuncture was significant. This type of attention from an authority figure with institutionally legitimate credentials pushed acupuncture one step closer to integration and legitimacy within or alongside conventional biomedical institutions (see Ruggie 2004). As more institutionally legitimate actors learned more about and even began utilizing this more marginal practice, it became even more legitimate in itself.

Acupuncture received a similar boost in legitimacy from British physician and eminent historian Joseph Needham, one of the earliest and still one of the most thorough researchers and proponents of Chinese medicine in general and acupuncture in particular. As a result of the research and advocacy by physicians such as Mann and Needham, a practice called “Medical Acupuncture” emerged. This differs from the

"Traditional Chinese Medicine" advocated by Mao that is taught in most acupuncture schools in the United States. Advocates of Medical Acupuncture are often physicians who practice acupuncture based on "scientific" (Western) principles, rather than the Traditional Chinese Medical principles taught in most acupuncture training schools. Medical acupuncture is practiced by physicians (MDs) who receive training in their medical schools or secure training in acupuncture techniques elsewhere (American Academy of Medical Acupuncture).

From the Carnival to the Medical Marketplace

In 1972, Stanford University hosted a symposium on acupuncture attended by 1,400 physicians. Whorton quotes a medical reporter at the Stanford symposium, who described it "as having a 'somewhat carnival-like' atmosphere, 'with hucksters taking orders for acupuncture charts and plastic dolls'; it 'was more what one might expect of a congregation assembled to witness Oral Roberts or some faith healer at work'" (2002: 266).

This characterization recalls descriptions of expositions held in the nineteenth century in the United States and Europe. For example:

> In 1838 merchant Nathan Dunn organized a Chinese Exhibition in Philadelphia (after first building a Chinese-inspired mansion of his own). More than a hundred thousand visitors viewed its 1,341 items, collected by Dunn and his friend William Wood, a journalist. The collection included a summer pavilion, manufactures, religious iconography, models of junks, and oil paintings of *hong* merchants, along with life-size wax figures of mandarins, priests, shopkeepers, literati, servants, actors, and ladies (Barnes 2005: 231).

Even more striking is the statement that the exhibit, "coming in the years after the first Opium War, was to rehabilitate the Chinese in foreign opinion" (Barnes 2005: 232).[1]

The carnival atmosphere no longer characterizes interactions between the medical approaches in the United States (or Europe) and China, although early Western students of Chinese medicine recalled experiences alive with electric energy. In 1980, David M. Eisenberg became the first exchange medical student to study in China, at the Beijing Institute of Traditional Chinese Medicine. He reflects: "There must have been something very potent in the water, air, or sociopolitical atmosphere of the 1970s that prompted a number of individuals to take parallel journeys to explore these 'other medicines' and 'nonconventional' approaches to health and illness" (2005: 10). Eisenberg's journey led him to become one of the most prolific writers on acupuncture and CAM, but he has not been alone; by 2002, over 14,000 acupuncturists were licensed in the United States, and 3,000 physicians had sought out formal training in acupuncture and practice it as part of their treatments (Eisenberg et al. 2002: 967). Currently, medical boards in 42 states and the District of Columbia offer licensing or certification for acupuncture (Acufinder 2009a).[2] By 2015, the number of acupuncturists in the United States may be as high as 40,000 (Cooper 2001: 56).

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[1] In addition to the political, there were cultural interests in the Chinese as the exotic "Other." Barnes mentions the popularity in Europe and the United States in "individuals viewed as racially or sexually exotic" (2005: 233, c.f. Garland-Thompson 1999).

[2] Although this is the case, certification requirements vary tremendously by state. For example, Illinois requires "NCCAOM certification in acupuncture, pass a clean needle technique course, have good moral character, and be at least 18 years of age" (Acufinder 2009b). Florida, on the other hand, lists Formal Education Requirements ("Completion of a three-year course of study in acupuncture and Oriental medicine and, effective July 1, 2001, a four-year course of study in acupuncture and Oriental medicine, which meets standards established by the board by rule," and "that applicants who apply for licensure on or after October 1, 2003 must have graduated from an ACAOM candidate or accredited four-year master's level program or foreign equivalent in Oriental medicine with a minimum [*sic*] of 2,700 hours of supervised instruction, 2 hours of medical errors, 15 hours of universal precautions, 3 hours of HIV/AIDS and 20 hours in Florida

After content analysis of medical journals from 1965 to 1999, Terri Winnick (2005) determined three distinct phases of physician responses to the increasing visibility and impact of acupuncture and other CAM. According to Winnick, early responses consisted of ridicule, warnings about exaggerated risk, and calls for government regulation. This condemnation phase lasted from the late 1960s to the early 1970s. From the mid-1970s through the early 1990s, this approach was reassessed and, as consumers were using CAM in larger numbers, authors in the journals assessed the potential role of patient dissatisfaction or weaknesses in conventional medicine. Finally, in the 1990s, authors moved away from attempts to outlaw CAM and towards attempts to understand CAM and even incorporate it into their own practices. It was also during this phase that authors began calling for CAM to be subjected to scientific scrutiny. According to Winnick, these changes reflect the process by which physicians, as a professional group, adapted to structural changes in the medical marketplace. Specifically, she points to relaxed medical licensing, managed care, consumerism, and the establishment of the Office of Alternative Medicine as important factors influencing this response. These structural changes, along with the increase in sheer numbers of acupuncturists in the United States, has increasingly brought different types of practitioners together, often treating the same patient. However, cooperation between the two practitioners is not assured, nor is compatibility between the two healthcare paradigms.

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statutes and rules" as well as 60 undergraduate college credits, "the NCCAOM written examinations consisting of the Foundations of Oriental Medicine Module and the Acupuncture Module," a practical exam (The NCCAOM Point Location Module), and dictates that the applicant is 18 years of age or more, as well as be a U.S. citizen, permanent resident or legal alien in the U.S. for six months prior to the date of application (Acufinder 2009c).

EAST VS. WEST: CULTURAL CONTADICTIONS OF MEDICINE

Harriet Beinfield, the acupuncturist quoted at the start of this chapter, describes herself as "the daughter of a surgeon and the granddaughter of two surgeons" who somehow came to be a licensed acupuncturist. She describes her experiences in detail:

> When Efrem [her partner and co-author] and I were first introduced to acupuncture at a seminar at Esalen[3] in the spring of 1972, there was tremendous upheaval in the world. The Chinese were in the midst of a cultural revolution, and so were we. During the sixties the concerns I wrestled with were more social than medical. Many of us were seeking to antidote the toxicity of racism in the American social body and heal the wounds inflicted by a decade of violence in Vietnam. I struggled to understand and reconcile how Western civilization, having achieved some outstanding accomplishments, could so often contribute to rather than alleviate human suffering. …
>
> To remake the world, it seemed we needed to rethink it (Beinfield and Korngold 1991: 4).

Beinfield's description sounds almost like a religious conversion. Her values initially seemed at odds with the reality of the social world in which she found herself. Seeking Truth, she found instead corruption. However, she made a point to say that the problems that pushed her towards acupuncture were not medical, but social.

Social reasons pushed Beinfield to embrace acupuncture, but that is not in any way meant to diminish the medical differences between the approaches (Beinfield and Korngold 1991). The ways in which a practitioner approaches the healing process is influenced by the practitioner's general worldview. They characterize the approach of physicians as similar to that of mechanics. According to this worldview, "nature and

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[3] Esalen is a center in Big Sur, California that provides "the intellectual freedom to consider systems of thought and feeling that lie beyond the current constraints of mainstream academia." According to the website, "The word [Esalen] itself summons up tantalizing visions of adventure, of unexplored frontiers, of human possibilities yet to be realized. … And then there are the people—the people who live there and love the land, and the 300,000 more who have come from all over the world to participate in Esalen's forty-year-long Olympics of the body, mind, and spirit, committing themselves not so much to "stronger, faster, higher" as to deeper, richer, more enduring. (Esalen).

humans are machines governed by mechanical laws… [and medicine] is the study of how the human machine works… [D]octors become like mechanics, …occasionally perform[ing] routine maintenance but mostly interven[ing] to execute emergency repairs" (Beinfield and Korngold 1991: 19). On the other hand, they describe the approach of Eastern medicine practitioners as similar to a gardener. According to this perspective, doctors, like gardeners, are meant to "cultivate life" (30). This approach to healing is also similar to the approach of Chief Seattle to nature, who in 1854 explained the relationship of humanity and the world:

> 'This we know—the earth does not belong to man, man belongs to the earth. All things are connected like the blood that unites one family. Whatever befalls the earth befalls the sons of the earth. Man did not weave the web of life; he is merely a strand of it. Whatever he does to the web, he does to himself' (quoted in Beinfield and Korngold 1991: 30).

The web metaphor is especially appropriate; as Doctor of Oriental Medicine Ted Kaptchuk (2000) explains, the Chinese worldview is of a "web that has no weaver." He explains that the web, or the universe, "is considered to be uncreated, but to exist through the dictates of its own inner nature: that is, through the constant unfolding of Yin and Yang. There is no 'truth' behind or above the things we see; there is no creator or first cause; yet the things we see continue, and their continuing is the eternal process of the universe" (Kaptchuk 2000: 296). He carefully qualifies his view, however, by noting that this "Chinese description of reality does not penetrate to a truth; it can only be a poetic description of a truth that cannot be grasped" (297). Truth, in this sense, cannot be known. This is in stark contrast to biomedical views as characterized by Beinfield and Korngold (1991), wherein truth is an answer to a question, a solution to a problem, and a way to fix what is broken.

Another difference between Western and Eastern medical approaches is related to Taoist Yin-Yang theory and involves the aspect of causation. Yin-Yang theory holds that no one entity can exist completely separate from other entities. Because of this interrelationship, "Yin and Yang must, necessarily, contain within themselves the possibility of opposition and change" (Kaptchuk 2000: 8). Kaptchuk, a frequent collaborator on research with physician David Eisenberg (an early student of Chinese Medicine whose experiences are mentioned above), explains the contrast between Western and Eastern medicine in the following way:

> For the Chinese, that web has no weaver, no creator; in the West the final concern is always the creator or cause and the phenomenon is merely its reflection…. Knowledge, within the Chinese framework, consists in the accurate perception of the inner movement of the web of phenomena. The desire for knowledge is the desire to understand the interrelationships or patterns within that web, and to become attuned to the unfolding dynamic (2000: 15).

Biomedical views of health and healing tend to be focused around the objectified body, isolating and attacking "disease" in order to rid the body of this invader (for example, see Kaptchuk 2000: 3). Thus, conventional medicine entails seeking to cure through ridding the body of disease, through invasive procedures if necessary.[4] In contrast to heroic "cure," researchers and practitioners favorable to CAM often portray it as a form of "care." For this reason, physicians are more likely to refer patients with chronic pain (those who need "care") to CAM providers than patients with acute

[4] Whorton traces the change of (what came to be) conventional medicine's approach from Hippocratic medicine, characterized by *vis medicatrix naturae*, or the healing power of nature, to "heroic" interventionist medicine. Hippocrates emphasized strengthening the ability of the human body to heal itself, and advocated avoiding interventions that might interfere with this process. By 1800, support of this claim was more theoretical than practical, and "practitioners' true enthusiasm was for the heroic interventions that took the work of cure out of nature's hands and placed it in physicians'" (2002: 6).

problems who need "heroic" intervention or invasive measures (see Shuval, Mizrachi, and Smetannikov 2002; Barnes et al. 2008).

Western and Eastern (specifically Chinese) medical thinking is clearly different. Is Chinese medicine, Kaptchuk asks, also a science? He contrasts it with the "Western" idea of science, "the relatively recent intellectual and technological development in the West" (2000: 18). Chinese medicine he characterizes as "a pre-scientific tradition that has survived into the modern age and remains another way of doing things. But it does resemble science in that it is grounded in conscientious observation of phenomena, guided by a rational, logically consistent, and communicable though process" (18-19). While strongly supportive of Chinese Medicine, he still feels that it is more poetic than scientific, arguing in favor of studying acupuncture and Chinese medicine in order to increase its legitimacy and credibility among biomedical practitioners. He is not in favor of removing acupuncture from the context of its epistemology, however. Acupuncture does better in clinical trials when practiced in its traditional context than when practiced "mechanically" in Western medical settings (Kaptchuk 2000: 24).

Despite the difficulty that sometimes arises when attempting to reconcile Western scientific testing methods with Eastern or alternative healing modalities, the popularity of such modalities has continued to grow over the years.

THE STATE OF ALTERNATIVE MEDICINES IN THE UNITED STATES TODAY

> Interest in complementary and alternative medicine (CAM) is sweeping the United States. CAM has become one of the fastest-growing fields in health care. Millions of people are spending billions of dollars, out of pocket, on therapies that until just recently physicians considered to be quackery. Although segments of the medical community remain skeptical, even dismissive, of the disparate set of practices and modalities that constitute CAM, some physicians are responding positively to their patients' interests, to recent developments in research, and to the new courses on alternative, complementary, integrative,

> and holistic medicine being offered by medical schools. Government has also turned its attention to the growth of CAM and, in fact, is contributing to it by spending millions of dollars to fund research on the safety and efficacy of certain therapies (Ruggie, 2004: 2).

With these assertions, Ruggie sets out to explicate the shifts in complementary and alternative medicine (CAM) occurring in the United States. She examines physician responses to CAM, the ways in which patients understand and use CAM and why they do so, issues surrounding the study of CAM, and potential difficulties and benefits of integrating CAM and biomedicine.

Alternative medicine is a set of practices different from biomedicine for preserving health and treating health-related problems. Saks (2003) adds that these alternative approaches are characterized by their political marginality and the legal restrictions imposed upon them, as well as their lack of access to funding and medical legitimacy. While "alternative medicine" sets itself against biomedicine, "complementary" medicine refers to a view of alternative medicine as practices that can supplement biomedical treatment, which retains primacy. Integrative medicine refers to a view of alternative practices that can be combined with biomedical practices. Each practice may treat difference aspects of the patient's problems, but both are important to the treatment (see Goldner 2004).

As Ruggie emphasizes, more and more people in the United States are turning to alternative and complementary therapies, either in addition to or instead of conventional approaches. Based on a survey conducted in 1997, Eisenberg et al (1998) estimated that 42.1% of Americans used some form of CAM, up from an estimated 33.8% in 1990. A recent study of Americans over the age of 65 found that 88% used some form of CAM (Ness et al. 2005).

These numbers may seem unduly high, but note that CAM is defined broadly in both studies, including chiropractic and dietary supplements (such as megavitamins) as well as meditation and breathing practices. In a sample of U.S. adults, Tindle et al (2002) found that about 35% of respondents used some form of CAM. The most commonly used form was herbs (18.6% of sample), followed by relaxation techniques, including meditation and guided imagery (14.2%). Acupuncture was tenth on the list of eighteen (1%) but third among the modalities that are solely practitioner-based, behind chiropractic (7.4%) and massage (4.9%).[5]

A study conducted in 2007 by the National Center for Complementary and Alternative Medicine estimated that 38.3% of Americans use CAM, up from 36% in 2002 (Barnes et al. 2008). In this study, CAM was divided into four categories: biologically based therapies, manipulative and body-based therapies, mind-body therapies, and alternative medical systems. The most commonly used of the biologically based therapies were "nonvitamin nonmineral natural products"; 17.7% of the sample had used such products as fish oil/Omega 3, Echinacea, or Ginkgo Biloba. The two most common manipulative and body-based therapies were chiropractic and massage; 7.5% of the respondents had used chiropractic in 2002; when osteopathic manipulation was added in 2007, the percentage was 8.6%. In 2008, 8.3% had used massage, up from 5% in 2002. Prayer was included in 2002 as a mind-body therapy (55%) but it was not included in 2007. The most popular mind-body therapies at that time were deep breathing exercises (12.7%), and meditation (9.4%). Finally, alternative medical systems include

[5] The practitioner-based CAM modalities more commonly used than acupuncture include chiropractic and massage. CAM modalities that can be either self-care or practitioner-based that are more commonly used than acupuncture are more numerous; among them are diets (e.g. Atkins), vitamins, homeopathy, yoga, and tai chi, in addition to those mentioned above (Tindle et al. 2005).

acupuncture, ayurveda, homeopathy, and naturopathy. Acupuncture and homeopathy were the most popular; in 2007 acupuncture had been used by 1.4% or over 3.1 million people in the United States in the previous year (Barnes et al 2004, 2008).

Even conventional physicians are now incorporating CAM in greater numbers. Astin et al (1998) reviewed reports indicating that a substantial number of physicians are practicing and referring their patients for some form of CAM. The differences among types of CAM are significant, though. Rates of practice vary across types of modalities and among studies; some studies have reported high percentages of physicians practicing herbal supplements, for example, while some found no physicians practicing this treatment. Much of this disagreement may be due to the sampling methods of the different studies; physicians in each study were often limited to a small geographical area.

Another possible reason for differences in CAM use or referrals by physicians is variability in physicians' views of different modalities. Hirschkorn and Bourgeault (2005) proposed a five-part conceptual framework to explain whether or not a healthcare provider would use or refer patients to biomedical or CAM approaches, arguing that characteristics of the practitioner, patient, CAM modality, structure (organizational), and context (sociocultural and political/economic) all influence a healthcare provider's decision.

Physicians and patients are not the only important actors with regard to the use of CAM. Following Hirschkorn and Bourgeault (2005), attention must be paid to specific characteristics of the CAM modality (epistemological foundations and political status), the social, cultural, political, and economic context, and the organizational structures in which referring practitioners are located. For example, we might expect a CAM

modality to be more acceptable to physicians in the United States if its epistemological foundations are deemed rational (since rationality is a valued and legitimate characteristic), if it originates in a state that has positive or neutral relations with the United States, if it is legal, available and not too expensive (or even better, is covered by health insurance), and if the physician is in a position to learn more about the particular modality.

Boundaries Between Alternative and Conventional Medicines

Challenges from CAM to the authority and dominance of conventional medicine were met with the building of boundaries between the old and the new practices. Lamont and Molnár (2002: 168) identify two types of boundaries, one of which is social boundaries: "objectified forms of social differences manifested in unequal access to and unequal distribution of resources (material and nonmaterial) and social opportunities." In contrast to the social boundaries are symbolic boundaries, which are "conceptual distinctions made by social actors to categorize objects, people, practices, and even time and space" and serve to "separate people into groups and generate feelings of similarity and group membership" (Lamont and Molnár 2002: 168). Social boundaries consist of task differentiation (Abbott 1988), spatial separation, and limits to collaboration or communication; symbolic boundaries are similar to the moral divisions maintained by social groups that are highlighted by studies of cultural and social movements (for example, Lamont 2000, Polletta and Jasper 2001).

Symbolic boundaries become especially important when social or structural boundaries are permeable (Lamont and Molnár 2002: 168). Once social boundaries (such as task differentiation) become blurred, clear symbolic boundaries are necessary to

maintain professional jurisdiction. As CAM therapies become increasingly mainstream, conventional practitioners may solidify or strengthen symbolic boundaries in order to maintain jurisdictional control in healthcare institutions. They may also attempt to limit the crossing of social boundaries by maintaining task differentiation.

Changes in the ways in which biomedical actors and institutions react to CAM have indeed been occurring, as Winnick (2005) outlines in her content analysis of medical journals. Interactions between CAM practitioners or organizations and conventional medical practitioners or organizations vary, however, depending on the CAM modality (Hirschkorn and Bourgeault 2005). For example, Goldner hypothesizes that relationships between acupuncturists and physicians will not be as tense from the outset than relationships between chiropractors and physicians, since chiropractors took the American Medical Association to court for attempting to limit the right of chiropractors to practice (2004, see Whorton 2002 for a detailed history). She also cites work predicting the co-optation of acupuncture by physicians (Wardwell 1994, Goldstein et al. 1985, and Wolpe 1985). The fear of co-optation may further inspire acupuncturists to distinguish their practice from conventional medicine.

That is not to say that all physicians would like to co-opt acupuncture. Some physicians would like to distance themselves and their practice as much as possible from these "make-believe" medicines, as physician George Ulett (2003) describes Traditional Chinese Medicine. In an article in the magazine *Skeptical Inquirer* entitled "Acupuncture, Magic, and Make-Believe," he describes acupuncture in the following way:

> Traditional Chinese acupuncture is an archaic procedure of inserting needles through the skin over imaginary channels in accord with rules developed from pre-scientific superstition and numerological beliefs. New research has replaced

> this mystical sham medical procedure with a simple evidence-based no-needle treatment that stimulates motor points and nerve junctures and induces gene-expression of neurochemicals and activates brain areas important for healing. This is a scientifically based alternative to the previous metaphysical theories and magical rituals (Ulett 2003).

While for some physicians, exposure to acupuncture in medical school can make them more supportive of the practice, Ulett warns against incorporating such alternative medicine into the curricula of medical schools, claiming,

> The integration of unproven mystical methods will serve only to contaminate a scientific curriculum with make-believe medicine. Evidence-based neuro-electric stimulation is an effective, simple, no-needle, drug-free method of treatment that can be taught in an hour's time (Ulett and Han 2002). Our own experience and reports from clinics abroad have shown this to be a potent technique giving lasting relief from chronic pain with a reduced dependency upon medication. (Ulett 2003)

In this way, Ulett implies that medicine has outgrown acupuncture. This type of thinking is not conducive to integrative medicine, since in the unlikely case of physician cooperation, contributions made by the acupuncturist are liable to be belittled or disregarded.

Warnings such as the above, while not necessarily reflective of the general opinion of physicians, are not entirely uncommon. In July, 2006, for example, the online newsletter for acupuncturists, *Acupuncture Today*, warned of the American Medical Association's recent attempts to reign in the growing popularity of alternative health care, and presumably its use. Specifically, the article warns its readers:

> The AMA's House of Delegates has adopted a resolution that calls for the association, in conjunction with an association-supported entity known as the "Scope of Practice Partnership," to study the qualifications, education and academic requirements of "limited-licensure health care providers and limited independent practitioners," such as licensed acupuncturists (Acupuncture Today 2006a).

In addition to reporting on the incursion of biomedical interests into acupuncturists' autonomy, the article highlights the response of the American Association of Oriental Medicine (AAOM), which the article quotes at length:

> Resolution 814 claims that 'the education and certification standards for limited-licensure health care providers may not be uniform nor well-defined nor generally understood by physicians and the public. In fact, there are uniform national and international standards for licensed acupuncturists…. There are a number of possible solutions for medics who do not understand the acupuncture and Oriental medicine (AOM) educational and practice standards. These include programs in medical schools so that MDs are more informed and can more effectively employ systems-based care in the interest of the patient and AOM (Acupuncture Today 2006a).

The AAOM urges biomedical physicians to learn about training on their own time if they are interested, rather than impinging on the ability of acupuncturists' professional association to regulate their own practitioners. A follow-up editorial entitled "Stonewalling Patient Choice" presented the issue as one of politicians interfering with healthcare practitioners. Authors indicated that this interference was selective, however, and that politicians' decisions about regulating healthcare were influenced by their own ties to "organized medicine," and were thus detrimental to patient choice (Acupuncture Today 2006b).

Exposure to alternative practices as part of the education of medical professionals familiarizes them with these alternative practices, potentially making them more comfortable with and perhaps more interested in incorporating them into their patients' treatment regimens than they otherwise would have been. In fact, in some medical schools alternative therapies are taught as part of the curriculum. Astin et al (1998) performed a literature search of rates at which physicians are practicing and referring patients to CAM, including acupuncture. Finding a rising rate, they concluded that physicians should make a conscious effort to understand these different practices.

Training and professional development will provide justifications of CAM and integrative medicine for supporters, or warnings about CAM for detractors. For example, Baugniet, Boon, and Østbye (2000) compare medical students to students of other healthcare practices in Canada; they find that the medical students had less exposure to CAM as part of their education, and had more negative attitudes. On the other hand, nursing students have more experience with CAM and more positive attitudes.

Summary

After a long struggle, biomedicine attained great legitimacy as the established, conventional mode of health care in the United States. It has positioned itself as scientific, empirically supported, and largely beyond reproach, in contrast to other competing forms of medicine, which came to be classified as alternative, or unconventional, practices. In the 1960s and 1970s, however, the authority and dominance of conventional medicine was challenged as a result of several conditions. Medical failures such as the thalidomide tragedy called into question the moral authority or legitimacy of conventional medicine, since it came to be widely seen as potentially harmful. The rise of the counter-culture movement and the fall of the diplomatic "Bamboo Curtain" between China and the United States resulted in receptivity to and excitement about Eastern forms of thinking and healing. Meanwhile, the move of medicine into the "medical marketplace" encouraged the commodification of healing. As consumers, patients began seeking healthcare providers and remedies outside dominant medical institutions because of their frustration with the limitations of conventional healing practices and the perceived failure of physicians to provide

satisfactory personalized care. Customer dissatisfaction does not frequently reflect a refusal on the part of individual physicians to provide acceptable care; both the ability of physicians to provide this care and the declining incentives for doing so have been influenced by changes in the organization of healthcare, such as the emergence of the managed care model.

While CAM is ever more widely used in the United States, it still remains marginalized. In this project, I examine this marginalization as it emerges in the form of social and symbolic boundaries between the professions of conventional medicine and acupuncture, as well as variations in the legitimating discourses used by each group. In the next chapter I will explain in more detail the key concepts of this study: boundary work and legitimating claims. After explaining the differences between social and symbolic boundary work and moral and cognitive legitimating claims more in detail, I will present my hypotheses regarding the use of these by physicians and acupuncturists.

Chapter Three: Theoretical Background
Complementary and Alternative Medicine as Social Movement

Today's rapidly changing healthcare field is comprised increasingly of previously marginal Complementary and Alternative Medicine (CAM) practitioners (e.g., acupuncturists, herbalists, chiropractors). An increasing number of people in the United States are turning to healthcare providers other than physicians to meet some of their healthcare needs. As these practitioners move into the mainstream, they are more frequently working with physicians, who remain the primary healthcare providers for the majority of people in the United States and who until recently held a virtual monopoly over health care institutions in the United States. At the same time that many patients are choosing to incorporate alternative or complementary therapies, medical schools are beginning to teach future physicians about these therapies, and scholars inside and outside mainstream healthcare institutions are researching the effectiveness of these alternative therapies.

Healthcare institutions are changing in response to the demands of their patients and in light of the expanding territory of medical knowledge. How do these changes affect the ways in which physicians and acupuncturists, as historically marginal practitioners in the United States, interact with each other as individuals and as professional groups? This study is designed to clarify our understandings of acupuncture, conventional medicine, and integrative medicine and the relationships of these practices and their practitioners.

In this chapter, I review the social movements literature about the role of individual activists as well as wide-scale institutional change, and recent developments regarding the concept of collective identity, as informed by cultural dimensions of social

movements research. I will also review relevant literature on professionalization and organizations. In these fields, the concepts of boundary work and legitimating claims, informed by studies of culture and organizations, will be important to the hypotheses I propose. Specifically, I use social movement concepts and theories to explain CAM as a social movement. This chapter provides the theoretical framework for the hypotheses I propose in the next chapter.

CAM AS A SOCIAL MOVEMENT

Classical resource mobilization theories focused on how social movement organizations secureing resources and thus ensure the survival of the social movement (McCarthy and Zald 1973 among others). While social movement organizations are undeniably important to social movement outcomes, other theorists recognized the importance of individual social movement actors and the wider social movement environment (see Tilly 1978, McAdam 1982, Staggenborg 1989, Kriesi 1995, Tarrow 1995, Gamson and Meyer 1996). Political process models introduced factors such as political opportunities, the role of elites in facilitating change, and countermovements, which develop in response to gains or threats made by social movements (see McAdam 1982, Tilly 1978, Useem and Zald 1982, Meyer and Staggenborg 1996).

Recent expansions of social movements theory have introduced the analysis of institutional change (Campbell 2005, Jenkins and Form 2005) in explaining how and why some social movements have a strong and widespread impact. A substantial amount of attention has been given to changes in healthcare institutions that have been at least partly due to healthcare social movements. Scott has looked at health social movements and the institutional environment in which they occur, in addition to examining the

institutional change that results. While trying to understand a localized change in the healthcare, Scott and fellow researchers realized they could not understand the localized change without examining change on state and national level (McAdam and Scott 2005). Others have also noted the importance of studying the environment in which healthcare changes occur (see also Brown et al. 2004, Clarke et al. 2003, and Goldner 2001).

Social movements that are able to provoke institutional change accomplish their goals by first securing participation and support of activists on an individual level. These individual activists can then affect change, in aggregate, on an institutional level (Taylor and Whittier 1992). One of the ways social movement organizations affect individual participants is the development of a strong collective identity.

By some standards, complementary and alternative medicine would not even be considered a social movement. Many social movement researchers hold that a key characteristic of social movements is their focus on securing change in political institutions (see for example Gurr 1970, McCarthy and Zald 1973, McAdam 1982, Quadagno 1992). Even research on social movements attempting to take cultural or environmental aspects of social movements into account often focuses on political outcomes (see for example Tarrow 1995, Stryker 2002).

Some scholars have expanded the definition of social movements. According to Gamson and Meyer, a social movement consists of "a sustained and self-conscious challenge to authorities or cultural codes by a field of actors (organizations and advocacy networks) some of whom employ extrainstitutional means of influence" (1996: 283). According to this definition, movements that challenge culturally specific understandings of reality but have no direct political aims may still be considered social movements.

Movements concerning health can easily be considered social movements, in this sense, since different understandings of health and science are cultural codes relevant to the goals and experiences of actors and organizations in health movements. The cultural codes challenged by health and science-oriented social movements, such as CAM, are strong and well institutionalized. Biomedicalization is indeed a process that has resulted in a highly institutionalized cultural code, and one that presents quite a challenge for those who wish to alter it (see Clarke et al 2003 for more on biomedicalization).

In Gamson and Meyer's terms, biomedical science and health care are stable cultural and institutional elements. In other words, this understanding of health issues is deeply grounded culturally (and individually-internalized), involving our values and worldviews (1996). It is also institutionalized, in government, healthcare, and educational institutions. Our understanding of how medicine works, who is an appropriate healthcare provider, and what medical institutions should look like are rooted in culture; adaptation to scientific developments, and the movements for legitimacy and authority on the behalf of Western medical professionals, have contributed to make these stable institutional elements. Therefore, changing these cultural codes is difficult and efforts to do so are likely to be highly contested. CAM has challenged these cultural codes, and contestation has been extensive in defense of biomedical institutions.

Frickel and Gross (2005: 206) call social movements like CAM scientific or intellectual movements (SIMs), which they define as "collective efforts to pursue research programs or projects for thought in the face of resistance from others in the scientific or intellectual community." This resistance would not be surprising to Gamson and Meyer, since challenging stable cultural elements such as worldview assumptions is

likely to be seen as more threatening than challenging more volatile cultural elements, such as particular political positions (1996).

Frickel and Gross (2005) posit that SIMs emerge under four conditions, all of which are relevant to complementary and alternative medicine. First, for a SIM to emerge, intellectual elites must be dissatisfied with "what they understand to be the central intellectual tendencies of the day" (209). Despite the centrality and predominance of biomedical approaches to health, such dissatisfaction is evident. Goldner (2004) found that some physicians felt that biomedicine was limited in its capacity to treat patients, since biomedicine does not treat patients holistically. Recently, the American Medical Association (AMA) invested in television spots attempting to elicit support for the AMA's efforts to speak up for patients, urging viewers to "help doctors help patients," by petitioning legislators who presumably can influence federal agencies and programs such as Medicare, affecting change in health and malpractice insurance rates (American Medical Association). Thus, it is clear that a significant number of intellectual elites (physicians) express dissatisfaction with the current state of healthcare affairs.

Second, SIMs are more likely to emerge when structural conditions allow the movements to secure resources. Insurance providers are increasingly making it financially possible for consumers to seek out CAM treatments (see Wolsko et al. 2002). Hospitals are incorporating CAM (see Cohen et al 2005) and governmental funding supports research on CAM therapies (the National Institutes of Health include the National Center for Complementary and Alternative Medicine, established in 1998). Finally, most states license CAM practitioners, and although certification procedures vary by state, groups of CAM practitioners and medical associations are pressing for standardization at the federal level (Cohen et al. 2005). In 2002, the White House

commissioned a study on Complementary and Alternative Medicine Policy, one of whose recommendations was that federal agencies "convene conferences of the leaders of CAM, conventional health, public health, evolving health professions, and the public; of educational institutions; and of appropriate organizations to facilitate establishment of CAM education and training guidelines" (WHCCAMP 2002). While not advocating CAM, the recommendations certainly represent openness to federal involvement. All of these factors highlight structural changes that facilitate resource acquisition by CAM activists.

Third, SIMs need access to micromobilization networks. Micromobilization has been important in social movement theories for some time; recruitment by social movement groups is easier if social movement actors can draw from extant networks, interpersonal or intergroup, in attracting new members (see Snow et al. 1980, 1986; Cable et al 1988; McAdam et al 1996). Hence, CAM's relationship to other health movements is important. Brown et al. (2004) identify three types of health movements whose members could be mobilized: health access movements (seeking equal access to healthcare), constituency-based movements (addressing inequalities in treatment based on race, ethnicity, class, gender, sexuality), and embodied health movements (addressing personal experiences with illness or disease and challenging diagnosis routines, treatment methods, etc.). CAM movement activists can emphasize their relevance to groups concerned with these issues; if successful, they can attract and mobilize groups already mobilized around related concerns.

Framing, a vital component of micromobilization processes, is the final condition highlighted by Frickel and Gross (2005). Members of the above groups are better mobilized in a scientific and intellectual movement opposed to conventional medicine if

the issue is framed in ways that resonate with them (see Snow et al. 1986). Kolker (2004) finds that frames served as cultural resources successfully used by breast cancer activists to reframe breast cancer as a public health problem worthy of public and government attention. As she emphasizes, such frame alignment can effectively mobilize activists, but to be most effective, the frame must also resonate with elites.

CAM and Collective Identity

Frames can be used to mobilize support from outside the movement; they can also be used to activate the collective identity of the activists, thereby helping to maintain their participation. Collective identity is a "shared sense of 'we'" that can be activated to mobilize action around a particular social problem or within a particular social movement (Griswold 2004). Collective identity consists of several components (Polletta and Jasper 2001). First, it includes an explanation of the community or social movement with which it is associated, explaining who the "we" is. Taylor and Whittier (1995) describe this as "the shared definition of a group that derives from members' common interests, experiences and solidarity" (172).

Additionally, collective identity is maintained by interactions with people "inside" and "outside" the movement or group, in the process defining the categories of "inside" and "outside" and thus boundaries around similar others (Polletta and Jasper 2001). Third, collective identity "channels words and actions, enabling some claims and deeds but delegitimating others" (298). In the broadest sense, collective identity constructs not only who groups of people are, but for those people, what the world is like, who belongs and who does not, and how to make sense of and act in it.

Collective identity is crucial for establishing the legitimacy of a social movement and its claims, particularly among its adherents. Collective identity tells a story about the person as a group member while also telling a story about the group. These narratives are important means of shaping the social reality of individuals and inspiring collective action suited to the aims of the social movement (see Hsu 2001, Roscigno and Danaher 2001). Certain explanations of the issue or the world in which the group exists may be necessary for the group to justify its actions or even its very existence.

A collective identity for CAM practitioners could be nurtured through educational institutions and professional associations, and may foster an oppositional understanding of the healthcare field relative to dominant conventional medicine. As such, CAM practitioners would be motivated to advocate for acceptance of their medicine and CAM, as a social movement, would be more effective than it otherwise would have been.

BOUNDARIES AND LEGITIMACY IN SOCIAL MOVEMENTS

Gamson and Meyer describe social movements as self-conscious challenges to the political or cultural *status quo* (1996), and advocates of CAM clearly fit this conceptualization. Complementary and alternative medical practitioners challenge the dominance of physicians and their claims to have sole jurisdiction over medical issues, and some scholars have examined these challenges and the institutional change that results. Shuval and Mizrachi, for example, have focused their work on boundary changes in mainstream medical institutions as alternative practitioners enter the "well-guarded fortress" of hospitals (2004; with Smetannikov 2002).

As actors in a social movement, the collective identities of both physicians and acupuncturists would be important. The training of physicians serves as a crucial vehicle for their development of a professional identity (see Becker 1977, Beagan 2000) and provides them with a specific understanding of the world and their place in it, along with a set of acceptable ways of behavior, or strategies of action, in Swidler's terms (1986). This process is well documented in the case of physicians, and it is likely that a similar situation would characterize acupuncture.

Ruggie (2004) argues that institutionally legitimate actors are necessary for marginal medical practices to make their way into the mainstream. In social movements literature, researchers have long held that insider or elite approval and cooperation, even if given as a response to perceptions of threat, is necessary for social movement success (see for instance Tilly 1978, McAdam 1982, Staggenborg 1989). Acupuncturists in particular would be likely to highlight the support of such legitimate others in order to increase their own credibility, prove entrée into legitimate spaces, and cross or erode boundaries.

BOUNDARIES AND LEGITIMACY IN PROFESSIONS

Social movements push for legitimacy and institutional change to advance their position (Stryker 2002). Research on institutions and organizations, especially research concerning professions, also provides insight into specific strategies for securing legitimacy and the nature of boundary work necessary for maintaining this legitimacy (see Abbott 1988).

Boundaries are aspects of collective identities (Taylor and Whittier 1995, Polletta and Jasper 2001), and they are also important aspects of the professional training people

receive (Abbott 1988). Timmermans and Kolker (2004: 178)) argue that practice guidelines are "the epistemological characteristics of, and control over, professional knowledge." It is important to keep knowledge protected and distinct in order to maintain control of it, and therefore to buttress the autonomy of the profession as a whole. Boundaries are delineated in terms of expertise and task divisions, i. e., what people in one position do that is distinct from what other persons do. The related task groupings, or occupations, then compete for jurisdictional control (Abbott 1988).

In health professions and institutions, processes of distinction are especially well-documented, and the growing popularity of CAM, along with other changes in the political and cultural landscape, have drawn into sharp relief the boundary work undertaken by actors in these areas (Shuval and Mizrachi 2004). Two types of boundary work are important in this situation: social boundaries, which practitioners physically separate, and symbolic boundaries, which keep them ideologically distinct (Lamont and Molnár 2002). Social boundaries are breaking down as CAM and conventional practitioners work together more frequently, in research or collaboration. As a result, we can expect symbolic boundaries to become more prominent, as physicians try to maintain the professional jurisdictional control for which they have fought so hard (Mizrachi, Shuval, and Gross 2005). These expectations will be explained in more detail in the following chapter.

Learned as a part of professional socialization, boundaries are necessary for maintaining jurisdictional legitimacy, or the exclusive control over a certain knowledge or practice (Abbott 1988). One way that legitimacy is recognized is in terms of certification bestowed as a result of training and licensing. In this way, a profession protects its knowledge, keeping interlopers away by requiring adherence to legitimated,

standardized guidelines. For example, before CAM therapies were certified, physicians could argue that they were the only ones in possession of a standardized body of healthcare knowledge. Obviously, with no legitimate competitors at the time, their professional dominance in the field of healthcare was assured.

To compete with institutionally legitimate competitors, an emerging profession incorporates standardizing practices, such as credentialing, to ensure that each member of the profession is offering the same or similar services based on a minimum level of knowledge and training. Whorton (2002) offers osteopaths as an illustrative example. Represented by organizations such as the California Osteopathic Association, osteopaths agreed in 1955 to inspections of their educational institutions by the American Medical Association; the inspection committee reported back that students were receiving a satisfactory medical education, and they were surprised also to find that many of the students could have gotten into "regular" medical school (Whorton 2002: 233-235).

These findings pushed osteopathy into the mainstream, despite continued opposition. Whorton notes that in the early 1950s in Bay City, Michigan, the physicians on staff of the hospital went so far as to resign in protest of the town council's vote to allow osteopaths hospital privileges. In a referendum, the town voted to rescind those privileges. Granting the AMA access to osteopathic educational institutions and regulatory power over certification processes was necessary for osteopathy to make strides towards legitimacy, through a biomedically facilitated transformation from osteopathy to osteopathic medicine. In 1961, the AMA resolved to remove the "cultist" designation from osteopathy, and when Medicare was established in 1965, osteopaths were specified for reimbursement, although naturopathy and chiropractic were denied (Whorton 2002: 235-241).

Organizations such the California Osteopathic Association and the American Medical Association play an important role in the association of a particular set of tasks with a particular "profession," and the acknowledgement that the professionals associated with those tasks are qualified to perform them.

Actors in developing professions will create and support organizations with institutionally legitimate forms, since this helps reduce organizational uncertainty. As Meyer and Rowan (1977: 340) suggest, "institutional rules function as myths which organizations incorporate, gaining legitimacy, resources, stability, and enhanced survival prospects. Organizations are structured around these rules, especially in emerging professions, where legitimacy is needed for professional survival. They are "myths" because they may not be the best way of operating, and they may not offer the most stability, but these rules fulfilled enhance the legitimacy of the organization, which may thus confer legitimacy upon the profession with which it is associated. Institutional legitimacy and standardization are adopted through using specific methods, going to certain training programs and organizations, and receiving acceptable certification. Because the members of the emerging profession have these shared experiences, collective identities are likely to emerge.

Training and professional development are key to constructing differences in perceptions of others as well as understandings of one's own work or occupations (e.g. integrative medicine, acupuncture, conventional medicine). Trainees learn a common body of knowledge, so that they are operating as a professional "whole," which is necessary in order to claim jurisdictional legitimacy, or the taken-for-granted expertise associated with their profession (Abbott 1988). In addition, training also socializes recipients into particular ways of behaving, reducing diversity within a particular

socialized group (Beagan 2000). Finally, training serves to socialize participants into a particular way of knowing, or epistemic perspective (Gieryn 1983).

Organizational standardization and the combination of a common knowledge base, behavioral set, and epistemology, create adherence to the same institutional rule set, and rituals performed around these institutional rules are likely to be reflected in narratives told by professions about the profession itself (Meyer and Rowan 1977). The narratives serve as legitimating devices for one's own profession and as delegitimating devices with regard to a competing or emerging professional group (see Saks 2003 for more about CAM as an alternative and competing occupational group). More generally research on organizational culture and neo-institutionalism leads us to believe that an emerging group will simultaneously present itself as both similar to competing groups – in order to gain legitimacy – and distinct from competing groups – in order to convey a unique identity, opening up a niche for itself (see Strandgaard Pederson and Dobbin 2006).

Professions are delineated along boundary lines, and extant professions seek to preserve their boundaries in order to maintain their jurisdictional and professional dominance. However, boundaries cannot always be maintained indefinitely. For instance, social boundaries were drastically weakened when CAM entered Israeli hospitals. Shuval and Mizrachi (2004) find that symbolic boundaries were crucial in the efforts of biomedical practitioners to maintain professional domination and epistemic superiority with the encroachment of CAM into the biomedical domain. Goldner (2004) found differences in the approaches to CAM depending on organizational context, so the extent to which practitioners maintain these symbolic and social boundaries may differ depending on the setting (e. g. hospitals, integrative clinics).

In this study, I examine the use of boundary work and legitimating claims by physicians and acupuncturists, those who work together and those who do not. The concept of collective identity provides a basis for hypothesizing about the types of boundary work and legitimating claims I expect to see from the different groups, as does the concept of professionalization.

SUMMARY OF RESEARCH

I interviewed acupuncturists and physicians, concentrating on questions of boundary work (how these individuals and professional groups maintain distinctions between them) and legitimating claims (how and to what extent they discuss their own professional practice as sufficient and appropriate, if not better, than those of competing groups). Through interviews with integrative and non-integrative physicians and acupuncturists, I add to the understanding of how the training and interactions of the practitioners influence their use of boundaries and legitimating claims when talking about and practicing acupuncture and conventional medicine.

This study contributes to scientific knowledge in several ways. Most importantly, it helps clarify the concepts of boundary work, legitimacy, and professional or collective identity and related processes. These are far-reaching concepts; boundary work and legitimacy are important in the literature of cultural sociology and organizations, and identity is an increasingly central concept in the study of social movements (collective identity) and organizations (professional identity).

The intersection of the two concepts is particularly interesting theoretically. For example, if we consider an emerging professional group as a social movement, oriented around securing a legitimate place for itself, the importance of boundary work and

legitimating claims becomes clear. The professional group must delineate itself from other potentially competing groups and also be strategic and definite about who exactly is in the professional group and what they do. Otherwise, the group will be too ambiguous to fit into its field. Legitimating claims help to present the group, once delineated, as useful or necessary.

Boundaries and legitimating claims are also important to the formation and maintenance of professional identities. Educational and professional socialization may strongly influence perceptions of one's own occupation (or emerging profession) and the occupational fields of competitors and coworkers; this in turn may influence the ways in which and extent to which professionals interact, thus influencing the shape of the field.

This study also contributes to the study of health social movements, a relatively new category of social movements, but one that is becoming increasingly important as health technologies, health needs, and health inequalities grow.

Chapter Four: Research Design:
Question, Methods, and Data

RESEARCH QUESTION

This project focuses on two key processes in the formation and maintenance of the collective identities of healthcare providers: legitimating claims or narratives (Polletta and Jasper 2001, Hsu 2001), and social and symbolic boundary work (Lamont and Molnár 2002). My goal in this study was to examine the ways these two important types of activities are carried out by four types of healthcare practitioners: non-integrative acupuncturists, non-integrative physicians, integrative acupuncturists, and integrative physicians (see Table 1).

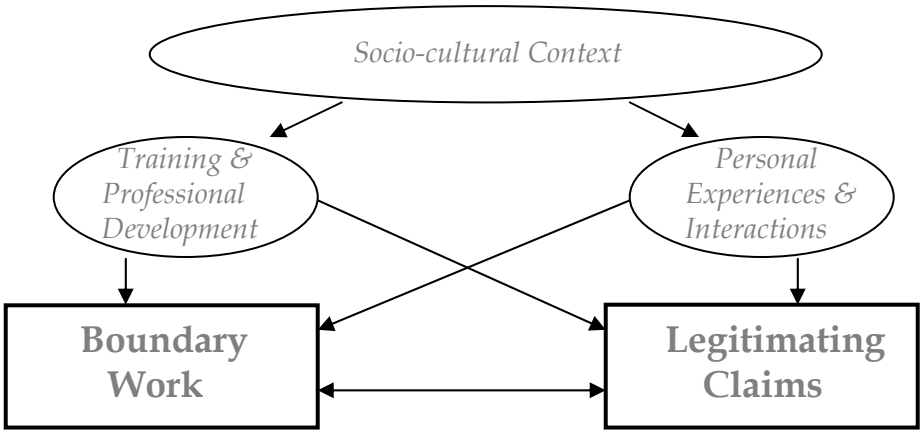
Table 1: Types of Practitioners.

Specialization:	***Acupuncture***	***Biomedicine***
Integrative (train or work with practitioners from paradigms other than one's own)	***Integrative Acupuncturists*** (train or work with physicians in the treatment of patients)	***Integrative Physicians*** (train or work with acupuncturists and possibly other CAM practitioners in the treatment of patients)
Non-integrative (decline to train or work with practitioners from paradigms other than one's own)	***Non-integrative Acupuncturists*** (do not train or work with physicians in the treatment of patients)	***Non-Integrative Physicians*** (do not train or work with acupuncturists and possibly other CAM practitioners in the treatment of patients)

I expected to find that boundary work and legitimating claims vary in accordance with the training and professional development of the practitioners and the type of practice they have chosen. In addition, interactions between members of the two groups and personal experiences with alternative healthcare approaches should influence the types of boundary work and legitimating claims used by practitioners. Diagram One presents this relationship schematically. The socio-cultural context

influences the two independent variables (training and professional development, personal experiences and interactions), and these two variables, in turn, influence the two dependent variables, boundary work and legitimating claims (below).

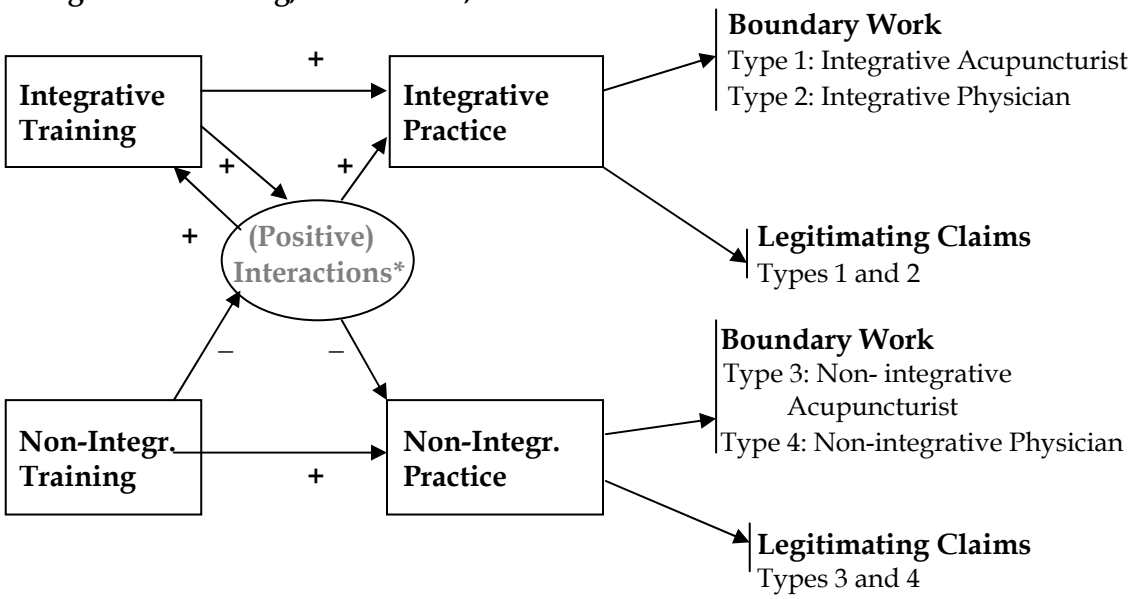
Diagram 1: General Model.



The proposed ways in which these variables are related are illustrated in Diagram Two. Interactions serve as an intervening variable between practice and training. Specifically, the nature of interactions with practitioners of biomedicine and CAM will influence the individual's decision to practice integrative medicine or not. Interactions can cause practitioners to change the type of practice they choose, even to the extent that they seek out new training. Training in one approach increases the likelihood that the person will practice in that field, but it does not necessitate it. A physician might seek out additional training to become a medical acupuncturist, for example. The specific types of expected boundary work and legitimating claims will be illustrated schematically following a detailed discussion of the hypotheses I have formulated based on the central research question of this study, namely the following:

> ***In what ways do integrative and non-integrative healthcare practitioners practice social and symbolic boundary work and use legitimating claims?***

Diagram 2: Training, Interactions, and Practice.



Intervening Variable: Interactions.

Lamont emphasizes the ongoing nature of social and symbolic boundary work (Lamont and Molnár 2002), both of which are evident among healthcare providers. Social boundaries, or the unequal access to resources and opportunities, will be maintained between the occupational groups, according to the literature on organizations and professionalization. Acupuncturists and biomedical physicians maintain separate practices and specialization claims in attempting to define, claim, or protect professional dominance (Freidson 1986) or jurisdictional control (Abbott 1988). The organizations literature leads us to expect that physicians, as the most institutionally dominant and legitimate group, will attempt to maintain their advantage in this area. As the history of alternative medicine indicates, biomedical physicians and their associations have, in fact, actively petitioned for the delegitimation of alternative practices, through efforts such as increasing federal regulations and decreasing autonomy through mandated physician supervision (Whorton 2002, Saks 2003).

Integrative practice, by definition, implies that social boundaries are relatively permeable; integrative practitioners work together in the same physical or professional spaces (Rees and Weil 2001). In that case, we can expect the strengthening of symbolic boundaries as a way of maintaining professional dominance and jurisdictional control, wherein one profession attempts to retain control over knowledge and practice in healthcare (Gieryn 1983). Symbolic boundary work consists of categorizing people and practices, such as acupuncture or integrative medicine, as having certain characteristics (e.g. logical, dangerous, unscientific, innovative). Scholars have argued that such symbolic boundaries allow biomedicine to maintain epistemic control over healthcare, despite the increasingly permeable social boundaries (Shuval and Mizrachi 2004, Hess 2004). This type of boundary work starts early, is formalized in places like educational institutions, and is continually undertaken in interactions with others of the same or alternative health paradigms.

For these reasons, I looked for correspondences between types of training (i.e. education, continuing education, and professional development) and the boundary work and legitimating claims made by integrative and non-integrative physicians and acupuncturists, as well as the interactions between then.

In this chapter, I go into detail about the concepts I use in my study: boundary work and legitimating claims. I offer hypotheses and the theoretical basis for each of them. Finally, I explain the methods I used to gather data to test these hypotheses and describe the data I gathered.

Boundary Work: Social and Symbolic

The first part of my research question concerns the extent to which the social boundary work carried out by practitioners varies according to the training they have pursued and the types of practices they have chosen. I expected social boundaries to be weaker among integrative practitioners, since by definition, they work with other types of practitioners. However, I expected social boundaries to still be discernible among integrative practitioners.

The work of Shuval and Mizrachi (2004) implies that three factors are important in the construction and maintenance of social boundaries: task differentiation (Abbott 1988), degree of cooperation, and spatial separation. Specifically, practitioners might seek to maintain task-specific specializations despite a seemingly more cooperative work environment. Overall, however, I expected integrative practitioners to emphasize cooperation more than distinction, indicating that they have weaker, or less prominent, social boundaries than non-integrative practitioners. To check the validity of the assumption about social boundaries, I questioned respondents about their daily working life, including the physical characteristics of their workplace, and the extent to which they are (or feel) geographically separated from other types of practitioners. Appendix One, Part One lists the concepts, indicators, and interview questions associated with the second research question and associated hypotheses.

***Hypothesis 1*:** **Integrative practitioners will have weaker social boundaries than non-integrative practitioners.**

The emergence of integrative medicine has introduced new organizational forms into the healthcare field in the United States. In addition, conventional medicine itself is changing. Some biomedical physicians are increasingly incorporating holism into their

practice, which may be, at least in part, in response to CAM's emergence and popularity (Whorton 2002). I expected this holistic approach to be more prominent in those biomedical physicians who have chosen to incorporate CAM into their practice. These integrative physicians have more exposure to holistic practices and training due to active cooperation with non-conventional therapies, such as acupuncture, outside their conventional training.

However, I expected integrative physicians to also attempt to maintain the professional dominance they have worked so hard to achieve. Even successfully co-opting a practice (to exaggerate the aims of many forms of integrative medicine) does not guarantee that one's own professional dominance will be maintained. To more closely protect their jurisdictional control and professional dominance, I expected that integrative biomedical physicians would draw symbolic boundaries between biomedicine and acupuncture. Thus, the second part of my research question asks, *To what extent does the symbolic boundary work carried out by practitioners vary according to the training they have pursued and the type of practice they have chosen?*

***Hypothesis 2a*: Integrative physicians will draw stronger symbolic boundaries than integrative acupuncturists in the face of weakening social boundaries.**

It is in physicians' professional interest to maintain distinctions between biomedicine and acupuncture, even in the context of integrative practice. At the same time, acupuncture has much to gain professionally by more closely associating itself with biomedicine, from the perspective of integrative acupuncturists. Emphasizing similarities with institutionally legitimate biomedicine may be useful in attempts by integrative acupuncturists to gain more legitimacy for their own profession. Specifically, I expected integrative acupuncturists to emphasize compatibility with biomedicine in

order to gain legitimacy. I also expected integrative acupuncturists would not emphasize symbolic boundaries as strongly or prominently as integrative physicians.

> ***Hypothesis 2b*: Integrative acupuncturists will have weaker symbolic boundaries than integrative physicians.**

The literature on organizations holds that an organization will attempt to fit into previous molds in order to gain legitimacy; at the same time it will attempt to distinguish itself to better compete with similar organizations (Strandgaard Pederson and Dobbin 2006). I predict a similar result regarding professional groups; unlike attempts by integrative practitioners to secure legitimacy by emphasizing their similarity to legitimate practices, I expect non-integrative acupuncturists to more actively try to distinguish themselves as a professional group. Compared to integrative acupuncturists, I expected non-integrative acupuncturists to draw more prominent or stronger symbolic boundaries between the two healthcare practices (acupuncture and biomedicine), attempting to more clearly define an occupational niche by highlighting acupuncture's distinctiveness from biomedicine.

> ***Hypothesis 3*: Compared to integrative acupuncturists, non-integrative acupuncturists will draw stronger symbolic boundaries between acupuncture and biomedicine.**

Table 2. Hypotheses: Boundary Work

Specialization:	***Acupuncture***	***Biomedicine***
Integrative	***Integrative Acupuncturists*** *Social†: weak* *Symbolic‡: weak*	***Integrative Physicians*** *Social: weak* *Symbolic: strong*
Non-integrative	***Non-integrative Acupuncturists*** *Social: strong* *Symbolic: strong*	***Non-Integrative Physicians*** *Social: strong* *Symbolic: strong*

†Strong social boundaries consist of high levels of task differentiation, a low degree of cooperation, and a high degree of spatial separation. Weak boundaries consist of low levels of task differentiation, a high degree of cooperation, and a low degree of geographical separation.
‡Strong symbolic boundaries consist of clear distinctions between the different healthcare paradigms, while weak boundaries consist of minimal ideological distinctions.

Appendix One, Part Two lists the concepts, indicators, and interview questions associated with the second research question and associated hypotheses. The hypotheses regarding boundary work, both social (H1) and symbolic (H2a, H2b, and H3), are summarized in Table Two above.

Legitimating Claims

Institutionalist theories emphasize mimetic isomorphism, or the replication of organizational forms as a means of securing legitimacy (DiMaggio and Powell 1983). However, legitimation is not simply the replication of organizational forms, but also the cognitively and morally justified acceptance of an innovation that eventually becomes taken-for-granted (Johnson, Dowd, and Ridgeway 2006). Since these legitimations are learned as part of the practitioners' education and socialization experiences, I expected them to be reflected in the narratives they tell about their work.

Cognitive legitimacy refers to the objective validity of a social phenomenon such as acupuncture. Moral legitimacy refers to evaluation and approval of a social phenomenon such as acupuncture. These two types of legitimacy are consistently important in the literatures on organizations, social psychology, and culture (Johnson et al. 2006). In addition, each of these types of legitimacy may be associated with legitimating claims, which may play an important part in the collective identity of acupuncturists and physicians, both integrative and non-integrative.

Legitimating Claims: Cognitive

The third part of my research question concerns the extent to which the cognitive legitimating claims made by practitioners vary according to the training they have pursued or the type of practice they have chosen. Cognitively, legitimating claims serve

a "sense-making" purpose, and therefore I expected them to emphasize compatibility of acupuncture and integrative medicine with our taken-for-granted understanding of the way the world works. I also expected cognitive legitimation claims to include assurances that acupuncture has secured the approval of "legitimate others." These two aspects are my next concern.

First, I expected integrative practitioners of both acupuncture and biomedicine (Medical Acupuncturists[6] or "moderates," as Goldner [2004] describes them), to portray acupuncture as compatible with biomedical views of health of healing, in order to gain credibility by linking the newcomer with an already legitimate institution. On the other hand, I did not expect non-integrative acupuncturists and physicians to do so, since they have little to gain by aligning the two healthcare paradigms. Rather, I expected non-integrative acupuncturists to portray acupuncture as a longstanding tradition, one which makes "sense" on its own without needing validation by biomedical explanations.

Biomedicine and biomedical healthcare institutions are highly reliant upon science for legitimacy, and upon scientific methods for testing new treatments. Even alternative therapies must subject themselves to testing within the biomedical paradigm and biomedical research institutions in order to gain acceptance (Whorton 2002, Kaptchuk 2000). In order to convey legitimacy, I expected integrative practitioners to portray acupuncture in terms of the testing that has been done, and even more broadly, in terms of the "science" behind acupuncture. For instance, rather that discussing such aspects of acupuncture (and the larger system of Traditional Chinese Medicine that encompasses it) as "chi," I expected integrationist biomedical doctors and

[6] See pp. 76-77, 83.

acupuncturists to discuss acupuncture in biomedical terms, perhaps emphasizing the role of endorphins or neurotransmitters or other familiar biomedical concepts. In this way, integrative practitioners might actively participate in sense-making by translating symbols with unclear meanings into symbols that audiences know and trust (Friedland and Alford 1991).

I expected integrative practitioners to focus on the ways in which acupuncture makes sense in "our world" (conventional biomedical institutions) in order to positively convey its legitimacy. By choosing to work with physicians, integrative acupuncturists have aligned themselves with actors who are currently legitimate in the dominant healthcare institutions. They may seek to influence those actors' understandings of health and well-being (e.g., by encouraging physicians to be more "holistic"), but by entering conventional medical institutions, these actors have at least implicitly agreed to work on their terms. The sensemaking component of legitimation, in these cases, must consist of "translating" acupuncture into biomedical terms.

> ***Hypothesis 4a:*** **Integrative practitioners, more so than non-integrative practitioners, will emphasize compatibility with biomedical views of health, healing, and science, as a form of cognitive legitimation.**

Since non-integrative acupuncturists must secure legitimacy outside the realm of conventional medicine, and since I expected that non-integrative physicians would not seek to legitimate acupuncture at all, I did not expect that these two groups would emphasize acupuncture's compatibility with biomedical views of health.

While I expected integrative acupuncturists and physicians to use scientific and institutionally legitimate language to make sense of why acupuncture works, I expected non-integrative acupuncturists to focus on the ways in which acupuncture makes sense in the world in which it originated. In this way, these actors would make sense of

acupuncture in the context of a long tradition of effectiveness. Rather than legitimation as a result of "scientization," acupuncture in this case receives legitimation through "traditionalization" -- its validity is indicated by its long history of effectiveness and its distinct niche is highlighted (acupuncture is different from biomedicine and effective in ways unknown to biomedicine).

Further, I expected non-integrative acupuncturists to use historical and anecdotal evidence for their claims of the effectiveness of acupuncture, rather than relying on biomedical studies. Specifically, I expected to see references to the long-standing history of acupuncture and allusions to continuity, e.g., "Acupuncture has a long history of effectively treating…" or "For thousands of years, acupuncture has been used for this purpose." I also expected non-integrative acupuncturists to refer to acupuncture as a "tradition," which would lend credibility to it as a "tried and true" form of health care (i. e., it has worked for thousands of years and it still works today). Describing acupuncture in these terms would provide a convenient means of distinguishing acupuncture from conventional biomedicine.

> ***Hypothesis 4b:*** **Non-integrative acupuncturists, more so than integrative acupuncturists, will emphasize historical background or longevity as a form of cognitive legitimation.**

In addition to sensemaking claims, cognitive legitimation may also consist of references to claims made by legitimate others. I expected integrative practitioners to refer to medical associations, biomedical experiments, and journal articles in order to convey legitimacy for acupuncture and integrative medicine. These legitimate others have already achieved considerable institutional credibility, and by alluding to these others, practitioners further indicate the "correctness" of acupuncture, especially when compared to possible other non-conventional treatments (e.g., massage, reiki). I expected

integrative practitioners not only to explain acupuncture and integrative medicine in biomedical terms for the purpose of sensemaking, but also to rely upon institutionally legitimate biomedical sources to support their claims that it is both effective and safe.

> ***Hypothesis 5*:** **Integrative practitioners will rely on legitimate others, in this case legitimate "scientific" studies, as a form of cognitive legitimation.**

I expected non-integrative physicians to refer to the lack of sufficient evidence from legitimate sources (e.g., "one study does not make it true") as an attempt to limit the transfer of legitimacy to acupuncture, while non-integrative acupuncturists would use entirely different sets of "legitimate others," focusing on historical evidence (see Hypothesis 4) or Chinese medical texts and experiments. Appendix One, Part Three lists the concepts, indicators, and interview questions associated with the third research question and associated hypotheses (H4a, H4b, and H5).

Legitimating Claims: Moral

The fourth part of my research question concerns the extent to which moral legitimating claims made by practitioners vary according to the training they have pursued or the type of practice they have chosen. Generally speaking, moral legitimating claims serve the purpose of comparing one thing favorably to another, with the purpose of asserting that one way of seeing or doing something is positive, or good. Moral legitimating claims could also take the form of unfavorable assertions: assertions that an alternative to that way of seeing or doing something is bad, or dangerous.

I expected moral legitimating claims to take several forms. For one thing, I expected acupuncturists to argue that biomedical practitioners focus on curing a disease while ignoring the whole person, and in the process dehumanize patients and neglect their care. They might also argue that the long history of acupuncture reveals the many

ways acupuncture provides patient care, resulting in a more holistic and respectful form of health and well being. Further, acupuncturists would argue that acupuncture, as a system of care, strengthens the whole patient, thus allowing the patient to heal him- or herself, similar to earlier *vis medicatrix naturae* approaches to healing. Non-integrative acupuncturists, more so than acupuncturists who choose to work with physicians, might also highlight specific problems with the biomedical paradigm, such as malpractice or invasive and risky procedures, as a way of highlighting the value of their own *separate* paradigm. I did not expect biomedical practitioners to rely on moral legitimating claims, but to focus instead on cognitive legitimation.

> ***Hypothesis 6a*: Non-integrative acupuncturists will highlight problems with the biomedical approach to healing, such as its limited focus on cure rather than care, and the dehumanization of patients as a form of moral legitimation.**
>
> ***Hypothesis 6b*: Non-integrative acupuncturists will highlight problems with biomedicine, such as incidents of malpractice, corruption, and invasiveness of the procedures as a form of moral delegitimation.**

Medical practitioners from different paradigms who have actively chosen not to work together are likely to express negative views of the practices of the opposing group. However, I expected even the integrative physicians to adopt this negative tone. While they would express the benefits of integrative medicine, I expected them to differ in terms of how much autonomy they felt acupuncture deserved. At the outset I recognized the possibility that some of the integrative participants in this study would have chosen to practice in an integrative environment for reasons other than a strong belief in the potential of acupuncture; physicians may have chosen to do so for economic reasons, for example, or to protect patients that might be vulnerable to manipulation or trickery (Shuval, Mizrachi and Smetannikov 2002, Shuval and Mizrachi 2004, Goldner 2004), and acupuncturists may have chosen the integrative environment to benefit from

the institutional legitimacy conferred by practice with physicians (Shuval, Mizrachi and Smetannikov 2002, Shuval and Mizrachi 2004, Goldner 2004). Despite this, I expected integrative acupuncturists to argue in favor of their own profession's autonomy, more so than integrative physicians.

Specifically, I expected acupuncturists, both integrative and non-integrative, to argue that acupuncture does not need biomedical supervision or regulation, since biomedicine is not without its own problems yet does not automatically subject its own practitioners to direct supervision by outsiders. At the same time, I recognized the possibility that integrative and non-integrative physicians would feel that autonomy of acupuncture presents a potential threat to patients, and as such should be monitored by physicians, who have proven their devotion to patients, as a profession, in the course of a long process of legitimation.

> ***Hypothesis 7a*: As a form of moral legitimation, acupuncturists will argue in favor of their own autonomy, claiming that acupuncture can be successful as a stand-alone practice, and that acupuncturists are capable of operating without the supervision of a biomedical physician.**
>
> ***Hypothesis 7b*: As a form of moral delegitimation, physicians will argue against the autonomy of acupuncture, claiming that acupuncture should be practiced by or under the supervision (or at the very least, with the consultation) of a licensed biomedical physician.**

Appendix One, Part Four lists the concepts, indicators, and interview questions associated with the fourth research question and associated hypotheses. Hypotheses concerning all legitimating claims, both cognitive (H4a, H4b, H5) and moral (H6a, H6b, H7a, H7b) are summarized in Table Three below.

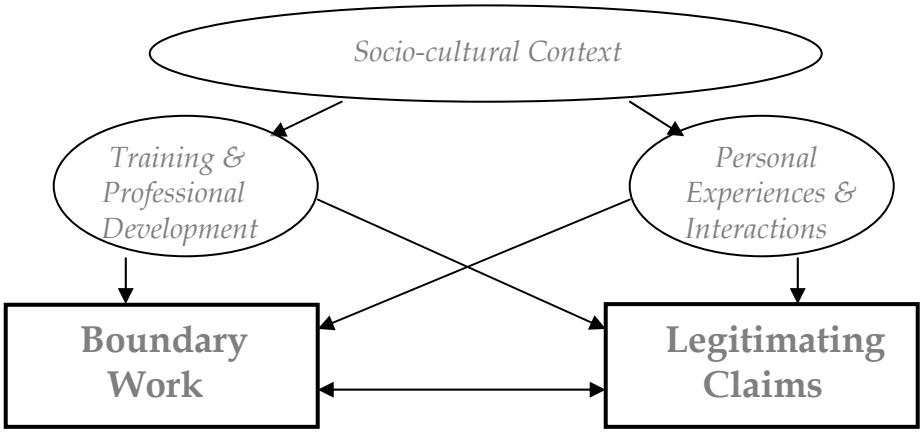
Table 3. Hypotheses: Legitimating Claims

	Acupuncturists	***Physicians***
Integrative	***Cognitive***: *- efficacy, safety of acupuncture; legitimate biomedical studies - sensemaking: acupuncture in biomedical terms* ***Moral***: *- acupuncture does not need biomedical supervision to safeguard the interests of patients*	***Cognitive***: *- efficacy, safety of acupuncture; legitimate biomedical studies - sensemaking: acupuncture in biomedical terms* ***Moral***: *- acupuncture should be monitored by physicians in order to protect the interest of patients*
Non-Integrative	***Cognitive***: *- efficacy, safety of acupuncture; historical and anecdotal evidence - sufficiency of acupuncture; historical and anecdotal evidence* ***Moral***: *- biomedicine is dehumanizing - biomedicine is fraught with malpractice, corruption, invasiveness -acupuncture is better without biomedical interference*	***Cognitive***: *- sufficiency of biomedicine - problems with CAM (lack of standardization in training and practice, inefficacy* ***Moral***: *- acupuncture should be monitored by physicians in order to protect the interest of patients*

Summary

In this study I use qualitative methods to closely examine two key aspects of the collective identity of healthcare practitioners in the United States: boundary work and legitimation. The general model is represented schematically in Diagram Three below. Square boxes indicate the dependent variables (boundary work and legitimation), ovals indicated independent variables. "Socio-cultural context" in the diagram refers to the histories of conventional and complementary and alternative medicine (specifically acupuncture) in the United States, the degree of cultural emphasis on science and rationalization, licensure and certification requirements, and the legitimacy of the "biomedical industrial complex," e.g., pharmaceutical companies, hospitals, private practices, as legitimate and dominant

Diagram 3: General Model.

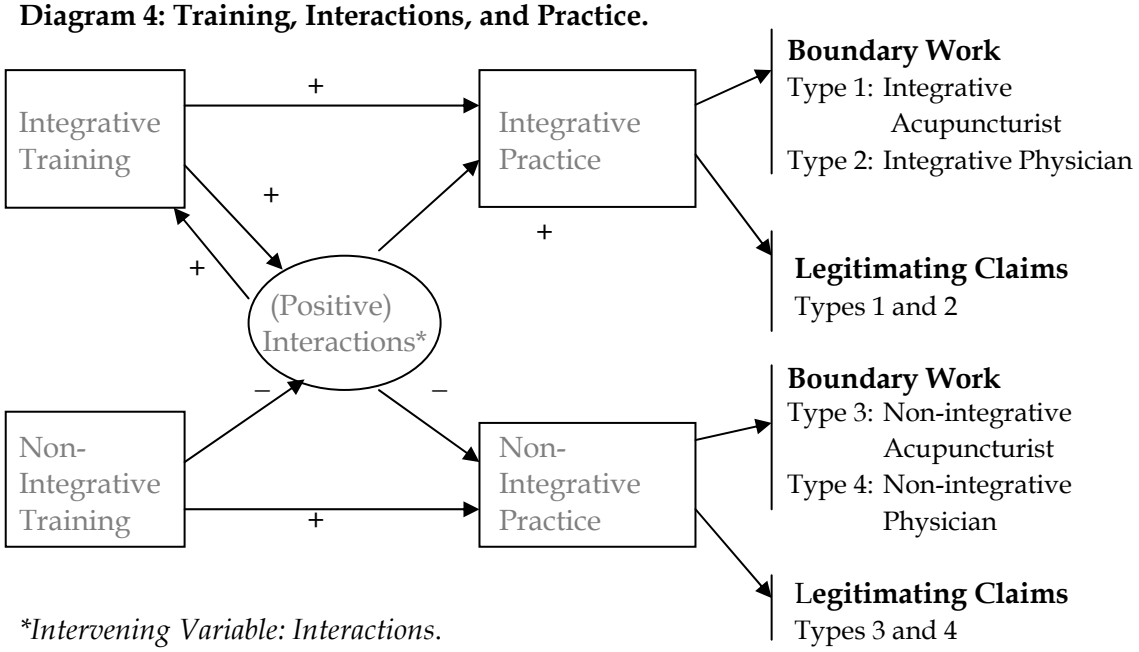


organizational forms. At the same time, the present socio-cultural context includes an economic market for CAM, which presents a challenge for the dominant (conventional medical) actors.

The independent variables are elaborated upon in Diagram Four below. Interactions between biomedical and CAM practitioners are represented as an intervening variable, since the nature of interactions between practitioners of biomedicine and CAM should influence the individual's decision to refer to other practitioners or work more closely with them. Interactions can cause practitioners to change the type of practice they choose. Diagram Four shows general relationships between training, practices, and interactions, and Diagrams Five, Six, and Seven (below) illustrate the more specific relationships between the independent and dependent variables.

Some of the components of the socio-cultural context that my influence the collective identities formed during the education and socialization of medical practitioners include a penchant for rationalism, "science" and especially biomedicine, the increasing relevance of globalization, and the increasing acceptance of CAM by insurance companies, usually provided a referral is given by a biomedical physician.

Diagram 4: Training, Interactions, and Practice.



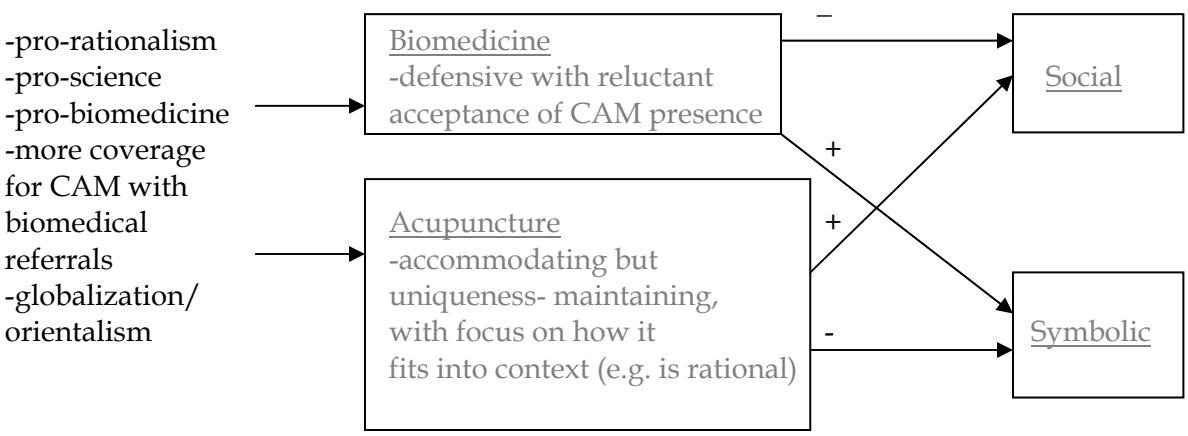
**Intervening Variable: Interactions.*

Diagrams Five and Six illustrate the type of boundary work I expect from medical practitioners, and why.

In Diagram Five (below), I illustrate my expectation that in the current socio-cultural context, training of conventional practitioners fosters a collective identity that is somewhat defensive but reluctantly accepting of CAM, including Chinese Medicine. Acupuncture training, in this context, fosters a collective identity that is accommodating but supports maintaining uniqueness, while also conveying compatibility with the socio-cultural context. For this reason, I expected integrative conventional medical practitioners to perform symbolic boundary work rather than social, and for integrative acupuncturists to perform very little or none of either.

Diagram Six (below) illustrates the less likely possibility that biomedical training would result in unwillingness to accept alternative practices, and that acupuncture training would create a collective identity that is defensive and separatist. For this

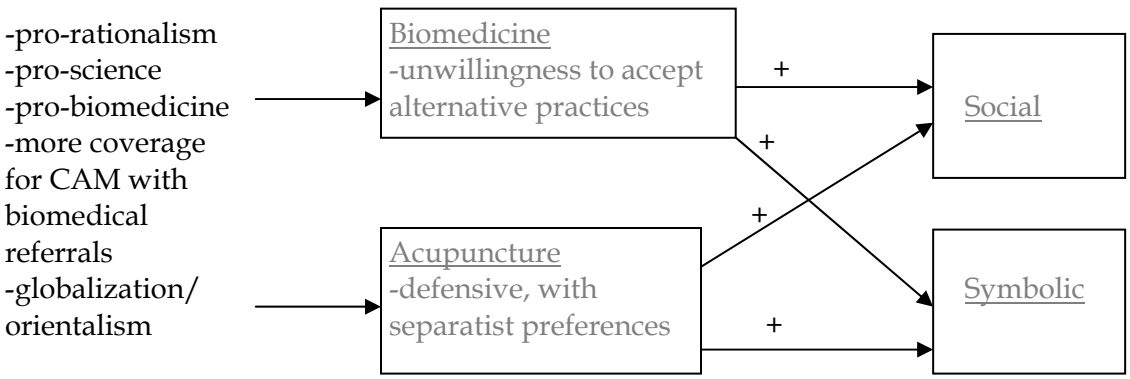
Diagram 5: Boundary Work/Integrative Practitioners.



reason I expected that non-integrative practitioners of both types would practice more boundary work of both social and symbolic natures than integrative.

Diagram Seven (below) indicates schematically the hypotheses regarding cognitive and moral legitimating claims. I expected cognitive legitimating claims to take the shape of 1) explanations of acupuncture in conventional/biomedical terms, and 2) reference to legitimate others, such as medical schools that teach CAM or studies in prestigious medical journals. I expected both of these types of cognitive legitimating

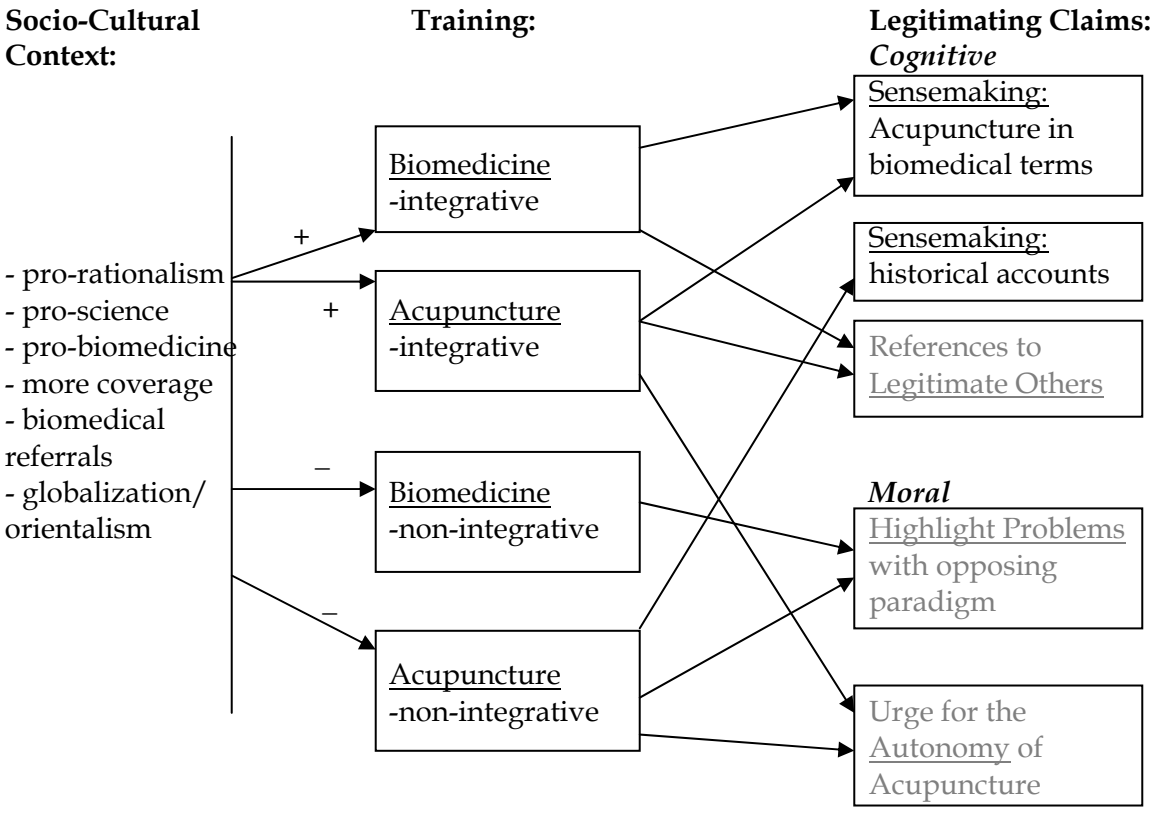
Diagram 6: Boundary Work/Non-Integrative Practitioners.



claims to be used primarily by integrative physicians (MDs) and acupuncturists (LAcs). I also expected that acupuncturists would make use of sensemaking claims that acupuncture was developed and has proven effective over thousands of years, and makes sense in the cultural accounts of that time period. I also expected that integrative acupuncturists, despite working with conventional practitioners, would use moral legitimating claims and argue that acupuncture is a good healing modality, and its practitioners should have autonomy.

I also expected non-integrative acupuncturists to make this argument in favor of the autonomy of acupuncturists. I also expected them to highlight problems with the opposing (conventional medical) paradigm. I expected non-integrative physicians, for

Diagram 7: Legitimating Claims.*



**Regarding the proposed influence of training on moral and cognitive legitimating claims: unmarked arrows indicate a positive influence; missing arrows indicate a negative influence.*

their part, to highlight problems with the opposing (acupuncture) paradigm. Finally, I expected non-integrative acupuncturists to use claims that acupuncture has a long illustrious history of doing good (moral legitimating claim in support of autonomy) and solving problems effectively (cognitive).

The above legitimating claims do not simply support the cognitive or moral legitimacy of the practitioners' paradigms; in addition, several of the arguments actually imply or include the position that the other paradigm is harmful, ineffective, or unnecessary. This reflects the broader tension between the two (at time) opposing approaches to healthcare.

RESEARCH DESIGN AND METHODS

To test my hypotheses, I used semi-structured, in-depth interviews of acupuncturists, physicians, and medical acupuncturists. I chose these groups of participants for several reasons. Since my research question concerns legitimating claims and boundary work, it was important to procure respondents on different sides of the expected boundary demarcations. I initially set out to interview four categories of practitioners: integrative acupuncturists, integrative physicians, non-integrative acupuncturists, and non-integrative physicians. However, during recruitment I decided on three different groups: acupuncturists (LAcs, most of whom were open to conventional medicine but not actively working with physicians), physicians (MDs, most of whom were open to acupuncture but not actively working with acupuncturists), and medical acupuncturists (MDAs, physicians who had also trained in and practice acupuncture). There is precedent for approaching these practitioners as distinct from conventional physicians; Goldner (2004) refers to this type of practitioner as a

"moderate."In some ways, these practitioners are integrating two types of thought (and practice), making them especially integrative and therefore a useful population for my study. I will discuss the reasons behind this change more fully below.

Because my research questions involve the daily practices of individual sense-making and boundary maintenance work, semi-structured interviews are appropriate -- they provide the richest data concerning individuals' experiences and interpretations of daily life (Creswell 1997, Silverman 1999). The use of in-depth interviews allowed me to tease out the ways in which symbolic and social boundaries are meaningful to the participants and the extent to which differences between biomedicine and acupuncture are incorporated into narratives about these different forms of medicine. Many of the questions I asked were open-ended, allowing respondents to elaborate on particular aspects they find most relevant, important, or familiar to them.

I expected that training in conventional medicine, which has a long history of exclusivity and esoteric specialization, would result in a specialized collective identity, supporting boundaries between their own practice and others, in order to protect their profession's jurisdictional legitimacy. I also expected that training in acupuncture would lead to a specialized collective identity, based less on protecting exclusive knowledge and more on shared experiences in a society of healthcare institutions unfavorable to alternatives that would encroach on their professional dominance. For this reason, I expected a collective identity that maintained defensive boundaries and incorporated claims asserting their own profession's legitimacy, thus making them suitable challengers to the dominant institutions.

Concepts and Indicators

My hypotheses depend on four main theoretical concepts: training and professional development, personal experiences and interactions, boundary work, and legitimating claims. The two independent variables are 1) training and professional development, and 2) personal experiences and interactions. Training and education is an important source of socialization for healthcare providers (Beagan 2000, Becker 1977), so I expected it to be important to the approach practitioners would take to practices different from their own. Professional development includes keeping up with advances in the field through reading academic journals or professional newsletters, attending conferences inside or outside their area of expertise, and attempts to further their knowledge, through continuing education classes either in their field or outside it.

My indicators of training and professional development are participant reports of the types of training and practice they have pursued over the course of their careers. Participants indicated training by including whether they practiced integrative or non-integrative biomedicine or acupuncture in their initial response to my recruitment letter (Appendix 3 contains the recruitment letter, and Appendices 4 and 5 are enclosures). Appendix Two contains the interview guides I used in the interviews. Participants indicated professional development during the course of the interview in response to direct questions about their participation in professional associations and meetings or continuing education courses.

I solicited information about the second important independent variable, personal experiences and interactions, by asking participants about significant past experiences with CAM or conventional medicine during the course of the interviews. Current experiences are used to gage social boundary work, and so are included below.

The third main concept, and one of the two dependent variables, is boundary work, which has two forms: social and symbolic. Indicators of social boundaries include task specialization (shared or differential access to opportunities to perform certain tasks), degree of collaboration (access to resources that come from working with another type of practitioner, including new or different forms of knowledge, or legitimacy when working with an institutionally legitimate practitioner), and spatial separation (access to resources specific to certain locations). In the interviews, I asked about the participants' experiences with each of the above indicators to determine the strength of social boundaries. These included questions such as "How much contact do you have with acupuncturists and how much contact do you have with physicians? How are the two types of interactions different, if at all? Does the frequency of contact with the two types differ?"

Symbolic boundary work, on the other hand, consists of drawing ideological or conceptual distinctions between different forms of healthcare or the epistemological bases of these forms of healthcare. Indicators of symbolic boundaries consist of explanations depicting different practices as similar (minimal ideological distinctions) or distinct and possibly incompatible (clear ideological distinctions). In order to measure these indicators, I asked respondents to describe their own as well as other practices, and any similarities or distinctions between their practice and other types. For example, I asked participants, "To the best of your knowledge, what are some differences between your approach to coming up with a diagnosis and treatment plan and the approach of others?"

The final important concept and dependent variable is legitimating claims, initially both cognitive (attributions of validity) and moral (attributions of goodness).[7] Indicators of cognitive legitimation consist of sense-making efforts and references to legitimate others. First, integrative practitioners are likely to make sense of their practice in biomedical terms, recognizing the primacy and legitimacy of this practice, and offering explanations of their successes as epistemologically compatible with biomedicine. Questions about this variable include, "How would you explain the successes of acupuncture?" or "How do you decide on a treatment plan for your patients?" Second, I expected participants to emphasize the successes of their alternative or complementary form of practice (including integrative medicine) by referring to legitimate others. Interview questions to measure these indicators included, "How do you keep up with the latest advancements in your field?" and "How would you explain your medicine to a patient who asked how it worked?" Responses to the latter question indicated sense-making legitimating claims, but could potentially reference legitimate others as well.

Indicators of moral legitimation include competitive or negative comparisons, and arguments about the appropriate amount of autonomy acupuncture should have. I expected non-integrative acupuncturists, more so than other groups, to highlight problems with the biomedical approach to healing (e.g. not holistic) as well as biomedical practice (e.g. malpractice) in order to indicate its danger or inappropriateness. Questions included, "How would you compare your approach to healthcare to a different approach?" with a follow-up prompt of "What are the strengths and weaknesses or your approach and acupuncture or conventional medicine?"

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[7] The emergence of a third component, pragmatic legitimating claims, will be discussed below.

Further, I expected most acupuncturists to argue in favor of their own autonomy, and most physicians to argue that biomedical physicians (and institutions) should monitor the practice of acupuncture in the best interests of patients. Questions measuring these indicators included "What role do you think physicians should play in the treatment of patients with acupuncture or other forms of CAM?"

Additional questions in the interview guide are based on the survey constructed by Hsiao et al (2005) to measure practitioners' orientations to integrative medicine, using several theoretically and empirically derived indicators. The survey measures respondents' openness, their readiness to refer to practitioners outside their own specialty, the extent and means by which they learn from alternative paradigms, the extent to which they are patient-centered in their approaches to health, and their feelings about the safety of integrative medicine. Examples of these included, "How do you provide your patients with the best possible care?" and "Has your approach to healthcare changed since you first entered the field?"

I pretested the interview guide with an acupuncturist I contacted early on in the project. The pretest allowed me to refine the questions to ensure that I was eliciting responses that would allow me to answer my larger research questions (Glaser and Strauss 1968, Creswell 1997). At that time, I realized that my interview guide was much too exhaustive. I decided to focus my questions on the examples listed above, leaving the others for the end if time allowed. I also decided to ask about the future of healthcare, since my first interview (and as I expected, subsequent interviews) provided me with arguments for a future that reflected the cognitive and morally legitimate healthcare desired by participants, and their visions of how and where boundary work

might remain. Appendix Eight contains the full coding system. I will return to this after a discussion of sampling and recruitment.

Sample Selection and Recruitment

Before beginning the recruitment, I secured professional development funding from the Graduate School of Emory University in order to provide participants with a small monetary gift in appreciation of their participation, and secured approval from the Institutional Review Board (IRB) for the recruitment, selection, and data gathering process.

To recruit participants, I first visited the website of the Medical Board of Georgia to obtain mailing addresses from their online directory for all acupuncturists licensed in Atlanta (LAc). I then obtained mailing addresses for general physicians and family medicine doctors (MDs) licensed in Atlanta, since these types of physicians are frequently primary care physicians and thus might receive questions from patients about acupuncture. I mailed letters (Appendix 3) to approximately thirty acupuncturists and approximately one hundred physicians, and enclosed forms by which they could request more information by mailing or faxing them to me (Appendices 4 and 5). I received very few initial responses from MDs, but many of the acupuncturists contacted me immediately. Those whom I interviewed received $25 in appreciation for their time.

For the second phase of recruitment, I applied for and received enough grant money to offer respondents $50 per interview, I shortened the proposed length of the interview to twenty to thirty minutes, and I purchased equipment to allow me to conduct phone interviews. With these changes, I was able to secure a sufficient number of physician participants. Because I was having so much trouble getting general

physicians to respond, I sent letters to approximately forty-five infertility doctors. I chose infertility doctors because I knew of relatively recent research on acupuncture treatments for infertility and reckoned that they might be more interested in participating. I looked up infertility centers in Atlanta using an Internet search engine and contacted every physician at the four biggest centers, receiving approximately ten responses, from which approximately seven interviews resulted. I also contacted four physicians recommended by Thomas, Aaron, Julie, and Kimberly (MDs), which unfortunately did not result in any interviews, and three acupuncturists recommended by Erin (LAc), which resulted in three interviews.

During recruitment, I found that the distinction between integrative and non-integrative practitioners was ambiguous. As I have also noted, it was very difficult to get physicians of any type to participate. For these reasons, I focused on getting as many physicians as I could, not letting the distinction between "integrative" and "non-integrative" prevent a potential participant from participating. It was at this point that I also added medical acupuncturists. The changes caused me to re-examine my theoretical approach. I decided to include medical acupuncturists, facing a sample with ambiguous distinctions between integrative and non-integrative practitioners, and facing emergent evidence from interviews with LAcs that medical acupuncturists may be important in the processes of boundary work and legitimation as well. I used the online database maintained by the American Academy of Medical Acupuncture to contact every registered medical acupuncturist in the Atlanta area (approximately a dozen), and eventually I had five willing medical acupuncturists (MDAs).

I intended to secure six to eight respondents in each of four categories: integrative physicians, integrative acupuncturists, non-integrative physicians, and non-

integrative acupuncturists. My final sample included twelve acupuncturists and thirteen physicians, with five of the physicians being medical acupuncturists.

In addition to the above, I also intended to have relatively equal numbers of male and female respondents, to limit the influence of gender, and I was hoping to secure both white and non-white respondents. Basic information about the respondents appears in Table 4, below: gender, race/ethnicity, and type of practice. Unknown designations resulted from conducting several interviews by phone. Individual practitioners are listed by pseudonym and type of practice in Appendix Seven. Each interview respondent completed a Written Consent form (Appendix 6a). When I conducted an interview over the phone, I obtained Verbal Consent (Appendix 6b). Each of these, as well as the interview guide and recruitment letters, was IRB approved (IRB00003046).

Table 4: Respondents

	Gender	Race/Ethnicity	Type of Practice
Acupuncturists (LAc)	M…...6 F…….6	White/Caucasian ….. 8 African American ….. 1 Chinese ……... 2 Japanese …….. 1	w/ other types …. 6 Private ……...….2 w/same types ….. 4
Physicians (MD)	M…...5 F……3	White/Caucasion ….. 5 Korean American ….. 1 Unknown……. 2	w/ other types ….. 1 Private …… 1 w/same types …... 6
Medical Acupuncturists (MDA)	M…...2 F……3	White/Caucasian ….. 3 Chinese ……... 1 Unknown …… 1	w/ other types ….. 2 Private …… 1 w/same types …... 0 Unknown ……... 2

In-depth Interviews

The in-depth interviews allowed me to tease out the ways in which symbolic and social boundaries are meaningful to the participants, and the extent to which practitioners incorporate differences between biomedicine and acupuncture into

narratives about their healing modalities. In-depth interviews were conducted based on the interview guide in Appendix 2. Many of the questions on the guide are open-ended, which allowed respondents to elaborate on particular aspects they found most relevant, important, or familiar to them.

Interviews varied in length from twenty minutes to over an hour. The longest interview was conducted with the acupuncturist with whom I pre-tested the interview guide; we ended up talking on two separate occasions for almost two hours total. The different interview lengths reflect several key differences. First, I shortened the length of the interviews in order to secure participation by physicians, so those tended to be shorter. Second, some of the practitioners seemed more interested in the topic, or had stronger feelings about it. These participants usually wanted to talk for longer. This was true for all three types of practitioners interviewed.

Usually, even the physicians usually talked more than the expected thirty minutes, however. I imagine this is a result of speaking with me in their offices over lunch, or in their cars or at home while they were not working. This removed them from the pressures to go see patients, and allowed them to spend more time in the interview. For their part, acupuncturists usually scheduled their interviews either over lunch or during a typical treatment time, which is generally an hour. Many gave me the last appointment of the day, or the last one before lunch, so they frequently gave me more than an hour, since they too were not feeling pressured to see the next patient.

Some acupuncturists schedule two patients an hour. Those who do typically speak with the patient for a little while, determine a treatment (i.e., which and how many needles to use, which meridians to target, which specific points would work best for that purpose), and then after inserting the needles, leave the patient to relax with

needles inserted, while beginning the next patient's appointment. They will then finish with the first patient while the second patient is relaxing with their own treatment. These practitioners often scheduled me for a thirty minute block, then left for a while when the next patient came in, and came back to finish the interview while that patient was relaxing in a treatment room.

I typically stayed at acupuncturists' offices longer than an hour, and frequently stayed about forty-five minutes with physicians. Participants of both types were generally very friendly, and interested in the project. Several asked if they would be able to read it afterwards. In addition, many did not want to take the money, and I often had to convince them that it was not technically mine, but that I had secured grant money to cover the cost, before they would accept it. I transcribed each interview and coded it using MaxQDA, a computer software package that facilitates the coding and organization of qualitative data.

In this study, I focused on theoretical extension, using previous theories of collective identity and professionalization, and specifically the concepts of legitimation and boundary work, to formulate predictions about a new population: acupuncturists (LAcs), medical physicians (MDs), and medical acupuncturists (MDAs) (Snow, Morrill, and Anderson 2003). My approach was both inductive and deductive. I began with an initial list of possible codes, derived from theory. I began coding the data during the interview process, and I noted as I went along that new themes and questions emerged. I thus incorporated new aspects of dependent variables as I continued interviewing (Miles and Huberman 1994). For example, I began with three main aspects of social boundaries: task differentiation, spatial separation, and degree of cooperation. As I continued the interviews, however, it became apparent that communication in general

was an important aspect of this as well, so added it to my coding scheme. Below I will provide descriptions and examples of the central codes.

First of all, as I have mentioned, social boundary work consists of task differentiation, spatial separation, and lack of cooperation. Task differentiation specifically included comments reflecting opinions about one modality being better or worse prepared to do specific tasks. For example, Thomas (MD) explained that "There's a cardiovascular risk associated with pregnancy, so she needs to see a cardiologist and then a perinatologist, and I'll kind of go on the second opinion there."

Degree of spatial separation, the second aspect of social boundaries, refers to comments reflecting the degree to which practitioners interact with other types of practitioners, as well as with those similar to themselves. In general, this refers to geographical distance. It can also refer to distinction between practices if the practitioner performs both. Hua (MDA) points out, "I do more of an integrated kind of thing, so I don't separate them. … For instance, if I see a patient in acupuncture clinic and if I see any conventional method can benefit the patient better, I will use the conventional part. Or if I see that I can do *both* then I would do both."

The third component of social boundaries is the degree of cooperation. In this sense, comments reflect the amount of cooperation between the practitioner and other types of practitioners, for example working together in the treatment regimen of a shared patient. Paul (LAc) noted that he often receives referrals from an MD when he or she "has tried epidurals, and drug medication, and nothing is really taking hold, or working… instead of using it in an integrative way, earlier on, where it may have been more relevant." I added the degree of communication, a similar but distinct component of social boundaries. Comments coded as such reflect the amount of communication

between the practitioner and other types of practitioners, for example, communicating about a shared patient's progress. When explaining how and why he would choose one acupuncturist to whom to refer a patient, Thomas (MD) remarked, "one of the things that I'd want in a relationship with the practitioner is to understand that, we'd feel fine for the patient to do acupuncture, but if they're going to push herbs and supplements on them, then I do have problems when they're doing IVF." Note that this comment reflects the importance of communication while also hinting at task differentiation.

The second type of boundary work I examined was symbolic boundary work. These symbolic boundaries are distinctions, both ideological and to some extent practical, between different healing modalities. Ideological differences might focus largely on cultural or philosophical differences. Sarah (MD), who is more familiar than other MDs with acupuncture, explains that "It's just a completely different way of thinking… it is and it's not compatible with [conventional medicine]. A Chinese medicine practitioner might not integrate any of [conventional] medicine. You know, they have their own way of thinking about it."

Practical distinctions, on the other hand, might focus more on cost, or time spent with the patient. While practical in nature, these qualities are used to create symbolic distinctions between the practices. For example, Paul (LAc) argues, "Now, it's not so much blaming physicians. I think—I blame more insurance companies, for low rates of reimbursals, which means staff of physicians overbook to make up for the shortfall of not getting paid, and so they end up having hardly any time."

The second main dependent variable in this study is the use of legitimating claims. I focused on two initially, and one more emerged. The first component of cognitive legitimating claims is general sense-making, specifically the use of stories

about the mechanisms by which healing modalities treat patients, and potentially linking these with theories and explanations that are already used or understand in the medical field. For example, Will (ACU) relies on Chinese medical explanations, rather than conventional, to explain:

> In the body there are meridians, or pathways, and these meridians or pathways have to be balanced. If you have too much qi in one meridian, it's not balanced. So we use acupuncture needles to either increase or decrease or decrease the flow of qi through these meridians, and as we do that, then, the body comes back into balance.

Practitioners might also use references to legitimating others, such as studies in approved journals using approved methods or the move of the practice into institutions such as schools or hospitals acceptable within the dominant paradigm: here, conventional medicine. Rachel (MDA) includes Chinese medical explanations and provides conventional scientific evidence in arguing:

> There's a large body of scientific evidence explaining the existence of the meridians, and then connection of the meridians, and also there's a large body of scientific evidence explaining-you know, when you stimulate with electroacupuncture, for example, it effects the substance T level at the spinal cord…

Another interesting source of cognitive legitimating claims came from popular culture. Paul (LAc) noted that "[People come in] who have seen it on Oprah, and 'If Oprah allowed it, then maybe it's ok.'"In this way, exposure in popular media makes the unfamiliar practice more familiar, and assures potential patients that it is a viable healthcare option.

Moral legitimating claims had five components in my final coding scheme. First, these comments addressed the perceived need for supervision of a particular healthcare

modality or its practitioners. Mark (MDA), when explaining how he would react to a patient questioning him about trying Chinese medicinal herbs, says, "Certainly I would tell them to be very-to question significantly to make sure where these herbs come from, how they're sourced, and-you know the FDA *doesn't* control it, so they can make any claims they want! … It's a non-controlled area."

Other comments reflected a moral decision about whether acupuncture should be used as an alternative or complementary medicine. Paul (LAc) argues, "There are certainly practitioners that would say 'Yeah, you don't need that drug, You don't need to go see that doctor, I'll take care of it,' and *that's* an alternative practitioner. But I don't think you'll see most acupuncturists practice like that at this point."

I also expected for purity and corruption to be used in moral legitimating claims, and found that danger was an important part of this code as well. These comments consist of references to a healing modality's potential for corruption, or dangerous outcome (or alternatively, purity). Thomas (MD) warns: "We have had some people who have totally unexplained, poor egg quality in IVF, and then they fess up to doing herbal medicine. Does that mean that that's the cause? Well, not necessarily, but I think it's something that throws an element in that you're really not controlling for."

Two aspects of moral legitimating claims that I added after coding began are the argument that one is quite simply *better* than the other, and that certain qualities exist which make a practitioner "good." For the former, comments reference one modality's worth or potential favorably in contrast to another's. Rachel (MA) explains,

> I just had a feeling that it was *better* for the patients because it allows the body to heal itself. There's no medicine in the needles; it just turns on the body's own healing mechanisms, whereas … all the serotonin reuptake inhibitors we've used for chronic pain, number one, have side effects, and number two in my experience, weren't that efficacious!

The latter could be used to encourage physicians to refer to or work with "good" practitioners, but can also be an impediment, as Thomas' comment illustrates: "If you were going to tell me that you need surgery, and I was going to refer you to a general surgeon, I know who's good, and who isn't-I know who's going to charge you fairly. As far as acupuncture, I don't know how to make that referral."

The third emergent type of legitimating claims is pragmatic. Aspects of these include an orientation towards results, and references to pharmaceuticals/herbs or insurance companies. First, comments coded as having a results orientation reflect a mindset that the important qualification of a healing modality is the potential benefit of it to the patient, reflected in whether or not the treatment works. Sarah (MD) cautions, "It's a little bit less easy to explain the mechanism, because we still don't know the mechanism of why it works. So it will be more like, 'I found it to be helpful,' or 'Studies have shown it to be helpful in such and such disease.'"

Many concerns expressed about TCM and conventional medicine were in the area of pharmaceuticals and herbs. Comments coded reflected a concern with the impact of these on patients or their other treatment regimens. At times, practitioners explained that this concern might come from the patients as well. For example, Paul (LAc) explains that he does not use herbs with all patients:

> [I focus more on acupuncture than herbs, since I feel that] people in the West, or in this country, are going to be a little more leery of taking herbs in a pharmaceutically dominated healthcare system, and acupuncture is strange enough on its own, and that the main thing it was going to be used for was pain relief—well, that's the frontline treatment, is acupuncture, for pain.

Patients and practitioners also expressed concern with the insurance industry and the healthcare industry in general. Comments coded as "Insurance Industry/Practice" refer to the insurance industry or the ways in which insurance

organizations function, and the practical implications of this. Sarah (MD) explains that her patients' insurance situation is an important factor in determining whether or not she will refer them to an acupuncturist. She explains, "Usually also it's easier with people who have good insurance that covers it … To pay for acupuncture $150 a visit, it's a big strain for them to pay, when they don't know if it's going to work or why it's working."

The final important aspect of pragmatic legitimating claims is reference to the healthcare industry or healthcare practices, and the practical implications of these two institutions. Paul (LAc) argues, "I still maintain in this country, it's primarily interventionist therapy, or modality, healthcare system. Go in, get the epidural, get the surgery, take the pills—and all that's fine, when somebody is suffering acutely."

Appendix Eight contains a list of all codes used in the final coding scheme, with codes added during the project noted as such. In the next chapters, I present the detailed findings from my data gathering and analysis regarding boundary work and legitimating claims.

Chapter Five: Social and Symbolic Boundaries
Working Together and Working Apart

In this chapter, I discuss my findings about boundary work, both social and symbolic. I will explain my findings in light of the hypotheses I proposed and discuss any unexpected findings as well. I will turn to legitimating claims in the next chapter.

The central issue is the amount of boundary work that different types of practitioners engage in. I expected that acupuncturists who work with physicians would do the least boundary work. First, their choice of integrative practice indicates a willingness to cooperate with mainstream medicine, de-emphasizing social boundaries. Second, as their profession moves into the mainstream, these professionals will minimize symbolic differences to facilitate increased cooperation.

I expected that non-integrative acupuncturists and physicians would do the most boundary work, since their lack of interest in cooperation hints that the two groups each see the other as too different to cooperate. If cooperation is attempted, I would expect it to be done with an emphasis on their distinctiveness, in order to protect jurisdictional authority.

Finally, I expected integrative physicians to be somewhere in between the two. Although they present a somewhat cooperative approach by choosing integrative medicine, they occupy the dominant position in the healthcare field, which might lead them to emphasize that despite cooperation, conventional medicine and its practitioners are still the authorities. Table Five shows the specific hypotheses for each type of boundary work, with formal statements of the main hypotheses regarding boundary work listed below the table.

Table 5. Hypotheses: Boundary Work

Specialization:	***Acupuncture***	***Biomedicine***
Integrative	***Integrative Acupuncturists*** *Social†: weak* *Symbolic‡: weak*	***Integrative Physicians*** *Social: weak* *Symbolic: strong*
Non-integrative	***Non-integrative Acupuncturists*** *Social: strong* *Symbolic: strong*	***Non-integrative Physicians*** *Social: strong* *Symbolic: strong*

†Strong social boundaries would consist of high levels of task differentiation, a low degree of cooperation, and a high degree of spatial separation, and weak boundaries would consist of low levels of task differentiation, a high degree of cooperation, and a low degree of geographical separation.
‡Strong symbolic boundaries would consist of clear distinctions between the different healthcare paradigms, and weak boundaries would consist of minimal ideological distinctions.

Hypothesis 1*:* Integrative practitioners will have weaker social boundaries than non-integrative practitioners.
Hypothesis 2a: Integrative physicians will draw stronger symbolic boundaries than integrative acupuncturists in the face of weakening social boundaries.
Hypothesis 2b: Integrative acupuncturists will have weaker symbolic boundaries than integrative physicians.
Hypothesis 3: Compared to integrative acupuncturists, non-integrative acupuncturists will draw stronger symbolic boundaries between acupuncture and biomedicine.

SOCIAL BOUNDARIES

Social boundaries refer to the means by which practitioners and practices are kept distinct. They have several components. First, task differentiation refers to the practice and conception of different professions serving different functions, that is, providing unique benefits that other professions cannot or do not provide. Second, distinct physical spaces maintain differences between professions by keeping them isolated from one another. Social boundaries are weaker when professionals share the same space. Third, social boundaries are a function of communication among practitioners. Routine cooperation and communication lower social boundaries, while the absence of communication helps maintain them.

I hypothesized that integrative practitioners would maintain weaker social boundaries than non-integrative practitioners (H1). I present evidence in support of this claim below for each of the three aspects of social boundaries. As in the previous chapter, quotes are identified by the practitioners' names and type of practice (Appendix 7).

Task differentiation

Many licensed acupuncturists (LAc) hold to the "Acupuncture as care, Western medicine as cure" distinction found in previous studies (e.g. Shuval and Mizrachi. 2004).[8] In the quote below, Adrian expounds on the ways in which his practice provides a necessary (perhaps even sufficient) complement or substitute for Western approaches. Western medicine cannot solve all problems, he indicates; patients are not getting the healing that they need from that approach, but he can provide it.

> So Western medicine is moving toward that area where Chinese medicine, say, has always had to shine because it didn't have the heroic interventional techniques. So it's much better in the realm of care, so—and now what's the big deal up at [the hospital] over there? It's like "cancer care" and like "holistic"… It's sort of like people exist after you go in and are a hero and cut something out! …
>
> Holistic is looking at people as sort of having more that, I don't know, having the larger emotions and everything like that. So Chinese Medicine embraces that, Chinese Medicine from the beginning has not had a mind-body split, Chinese Medicine thinks –has always thought—and I guess the earliest texts are like 3rd century B.C., I guess the dates are debatable, but you have the *Yellow Emperor's Internal Canon*, and they said "Anger is associated with the liver, and fear is associated with the kidneys" … so that's always been the case. (Adrian, LAc)

The LAc highlights the limitations of conventional medicine, thereby strengthening the social boundary between acupuncture and conventional medicine.

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[8] This at times seemed like an evaluative judgment, thus reflective of symbolic boundaries. The differences will be discussed in more detail below.

Medical doctors (MDs) maintained task differentiation as well. Instead of highlighting the ways in which acupuncture can make a unique contribution to the healing process, most MDs focused on symptomatic relief provided by acupuncture. For example, a few of the MDs who specialized in acupuncture acknowledged that acupuncture might be able to help with fertilization procedures. However, they more frequently described acupuncture as useful only indirectly, by relieving stress that might interfere with the success of infertility treatments.

Another way MDs conceptualized acupuncture was as a "last resort" approach. If a patient wanted to pursue alternative treatments, perhaps because conventional treatments were unsuccessful for unknown reasons, MDs might refer the patient to acupuncture. Acupuncture was suggested not because of specific *known* tasks it could accomplish, but rather, because MDs did not want to send patients away "empty handed" and hoped that some *unknown* contribution provided by acupuncture might be able to help. Several MDs referred to an acupuncture referral contact as something they have in their "toolboxes," while some MDAs used the same terminology in reference to the practice of acupuncture itself. This terminology is revealing in light of the analogy given by Kaptchuk (2000) of the "Western" medical approach to the body resembling that of mechanics to machines, and of "Eastern" approaches more closely resembling those of gardeners to gardens. While LAcs did not frequently compare acupuncture to fertilizer *per se*, they did frequently describe acupuncture as helping to strengthen the body's natural defenses and cultivating the body's own healing power, a task unlike the

heroic intervention possible through conventional medicine, although similar to Hippocratic medicine's ideal of *vis medicatrix naturae*.[9]

Every medical acupuncturist spoke with excitement about the possibilities provided by incorporating acupuncture into the treatment regimens of their patients. On the other hand, MDs were often skeptical but accepted the turn to acupuncture as a last resort. Many LAcs frequently expressed frustration with this type of task differentiation, specifically explaining that working together could potentially yield much better results, which was also reflected in the way acupuncture was often integrated into courses of treatment by MDAs. From this perspective, using acupuncture solely as a last resort might set it up from the start to be less successful than it might otherwise be, as Chen's comment indicates:

> [Some of my patients do not like MDs, but others] look for MD but didn't help. I have one patient, he's 55, and he has back pain…. He did three times surgery. Same place, three times. He said, "OK, first time I go to see the doctor, the doctor says 'You have to do surgery.'" …. But after surgery, still pain. [Upon the recommendation of the physician, he had surgery again.] Then after this, still pain. He did three times. OK, so lot of times they come to see me. And the acupuncture really helps, … but of course, if you don't do surgery, [it may be more effective]. But after surgery, sometimes gives acupuncturist more hard time. …. Scar tissue inside is just changing. So you can't very exactly find the points. (LAc)

As a rule, medical acupuncturists emphasized the usefulness of acupuncture in treating chronic problems, complementing Western treatments they could provide (again highlighting the acupuncture as care, conventional medicine as cure dichotomy). Several MDAs acknowledged that they would consider referring a patient to an LAc if what they were doing wasn't working, reflecting a sense that acupuncture is practiced differently by different practitioners and thus might accomplish different tasks. For

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[9] See Chapter 2, note 4.

example, a medical acupuncturist who shares a practice with two LAcs explained that some patients were more interested in or suited to the different types of Chinese Medicine practiced by her partners, Five Elements and TCM. For that reason, she might send a patient to one of them. One MDA described the decision-making process for determining which patients might benefit from acupuncture (or a different acupuncturist), this way:

> Well, the ones that remotely expressed an interest in acupuncture I usually did acupuncture on, because I was excited about it… [and] either they weren't getting better with Western medicine or I had seen that it had worked on other patients with similar conditions, and so I added in acupuncture as much as I could… It just turns on the body's own healing mechanisms, whereas Oxycontin, and Lyrica, and all the serotonin reuptake inhibitors we've used for chronic pain, number one, have side effects, and number two in my experience, weren't that efficacious! (Rachel, MDA)

The quote above illustrates another important point; medical acupuncturists may use the "tool" (their terminology) of acupuncture to set themselves apart from other MDs. Continuing the analogy offered above, in addition to using the "tools" of the mechanic, this MDA acknowledges that acupuncture allows her to cultivate the body as garden as well.

Many MDAs explained that acupuncture was helpful in treating side effects of medication, and they saw great benefit in limiting patients' medications through acupuncture (complemented by diet and exercise). In addition to easing symptoms caused by conventional treatments, pain specialists emphasized the potential of acupuncture as an alternative to surgery, which often didn't work.

> [A]cupuncture … essentially has no side effects when performed properly… I think there's more risk to Western medicine, including medications and surgical procedures than there is to acupuncture. … [A]dding something in like acupuncture to a practice can reduce the number having to go to surgery, the number of patients having to take medicines, and it's just common sense that it therefore reduces adverse effects. (Rachel, MDA)

While most MDs accepted the use of acupuncture in certain cases, most also expressed skepticism (often considerable) about herbal treatments. Some claimed that herbs, while not necessarily dangerous (but potentially; more about this below), have physiological effects that likely would interfere with the conventional medications that the patients were already taking. This fear is illustrated well by this physician's statement:

> We have had some people who have totally unexplained, poor egg quality in IVF, and then they fess up to doing herbal medicine. Does that mean that that's the cause? Well, not necessarily, but I think it's something that throws an element in that you're really not controlling for… So one of the things that I'd want in a relationship with the practitioner is to understand that we'd feel fine for the patient to do acupuncture, but if they're going to push herbs and supplements on them, then I do have problems when they're doing IVF. (Thomas, MD)

Although some MDs were skeptical of some aspects of acupuncture, and many were skeptical of the use of herbal medicine in conjunction with acupuncture, nevertheless the majority of MDs acknowledged that there is indeed a set of healing tasks manageable by acupuncture that are beyond either the scope or capabilities of conventional medicine. Both MDAs and LAcs highlighted the ways in which acupuncture can (at the very least) effectively supplement conventional treatments, and can provide the "care" so often missing from conventional medical "cures."

Spatial Separation

The practices of conventional medicine and acupuncture are often located in distinct places, thereby having fewer opportunities to interact. My expectation is that spatially based social boundaries are stronger between non-integrative practitioners

than their integrative counterparts. Close proximity allows for more communication and cooperation.

With a few exceptions, the LAcs involved in this study usually had private practices, or worked in practices with other acupuncturists. For example, one LAc, who practiced in a converted house with several chiropractors and massage therapists, was separated by the waiting room from the chiropractors' "wing" of the ranch-style house (the part-time massage therapists predominantly used chiropractors' treatment rooms). Several other LAcs shared spaces with chiropractors (including one who was enthusiastic about his work with them) and massage therapists. Only two of the LAcs shared spaces with physicians, although several MDAs did. Other than that, the physicians' spaces were kept distinct; acupuncturists who practiced with other types of practitioners more frequently practiced with other non-conventional ones. One MD-LAc practice, in a converted house, still maintained separate spaces in the house (offices and treatment rooms on different floors).

Most of the MD participants that I interviewed worked in clinics, although one had a private practice. MDs saw other MDs frequently and routinely discussed patients or problems they were having in treating someone. Almost all of the clinics were near or within hospitals. On the whole, physicians were spatially closer to physicians than to other types of practitioners, which allowed MDs to work together when they feel inclined. Kevin, a physician who worked in a practice within a hospital explained:

> We interact with other physicians all the time, especially in this type of environment, when you go downstairs and you have lunch in the physicians' dining room…. So we interact with them very frequently, and often will rely on each other for their expertise pretty frequently also. For example, I had a patient last week who needed surgery by an oncologist, and I was able to actually go down to the operating room on Friday, and see what they found during the procedure… (Kevin, MD)

Kevin went on to describe the dramatically smaller amount of access he has to alternative practitioners, including acupuncturists. Stories such as this one highlight the ease of practitioner interaction provided by geographical proximity. He rarely interacted with acupuncturists, although when one came in, she impressed him so much that he felt more comfortable referring patients to her. He explained that she gave a talk on the "philosophy behind what [she does], and it seems to be pretty in line with how we feel that patients should be treated" (Kevin, MD). Kevin was able to determine this compatibility between his and the acupuncturist's views of patient treatment only after speaking with her in person.

Obviously, face-to-face interaction is limited by spatial separation of the two types of practices. At the time of the interview, Kevin was preparing to move to a different clinic where an acupuncturist came in regularly to treat the practice's patients. He did not indicate any plans to work with the acupuncturist but was pleased at the potential for his patients to pursue complementary treatments without needing to travel to another location while still, presumably, under his (at least indirect) supervision.

The quotes above touch on a several aspects of spatially determined social boundaries. First, it is clear that spatial proximity facilitates the interaction of physicians. This interaction makes working together easier and presumably more appealing. Second, spatial proximity does not *necessitate* integration. This physician explains that he came to be interested in acupuncture based upon research, the apparent consensus of other physicians in the practice, and the ability of an acupuncturist to explain her practice in a way that "makes sense" (more on this below). Spatial proximity may lead to more discussions across modalities; this communication (more on this below) may weaken social boundaries. Only two acupuncture practices (out of 11 total) were located

near hospitals. By contrast, only one physician was in a building not near a hospital or in a clinical area (surrounded by healthcare centers and clinics). The lack of spatial proximity between acupuncturists and physicians and between acupuncturists and healthcare centers (such as hospitals) strengthens the social boundaries between the two types of healing modalities.

MDAs work in a variety of environments. Many have separate spaces for their two types of practices. For example, one MDA works with LAcs and several (conventional) psychiatrists and psychologists. LAcs in this practice use different treatment rooms from the conventional practitioners, and the MDA himself has two separate treatment rooms: one for conventional therapy, and one for acupuncture treatments. Other MDAs have more integrated spaces:

> [I]f I see a patient in acupuncture clinic and if I see any conventional method can benefit the patient better, I will use the conventional part. Or if I see that if I can do both then I would do both. The same way with my conventional clinic: I mean, if I see a patient who can benefit from acupuncture or from other things, then I will recommend those. So, I don't really try to separate [my practices]. It's just easier for scheduling [to do so]. (Hua, MDA)

Other MDAs provide interesting examples of the ways in which healing places are differentiated in line with task differentiation. Several MDAs practice acupuncture on certain days and not others, or have different locations in which they practice the different modalities. Even with the same person practicing both, integration of different types of medicine is not always maintained, which raises the question of whether or to what extent different types of medicine can be integrated. In this case, most MDAs in some ways maintain social boundaries between their own conventional and Chinese Medicine practices. However, these boundaries are not as strong as social boundaries between MDs and LAcs.

Cooperation and communication

Clearly, spatial separation can limit or encourage interaction between practitioners, potentially weakening social boundaries. One MDA, for example, spoke to several of the LAcs in his practice during the course of our interview. One was a nurse trained in Atlanta, another was an LAc trained in China. In both cases, he asked them about a Chinese diagnosis or herb in giving an example to me during the interview. This example indicates that close spatial proximity contributes to increased communication and cooperation in treating patients, an issue about which most practitioners seemed concerned. Several MDs and LAcs mentioned that communication was hindered by a lack of understanding on the part of MDs of the diagnostic system of Chinese medicine.

LAcs often lamented their inability to work with physicians, especially if they had done so in the past. Several LAcs had trained or interned with physicians or medical students and they regretted no longer being in an environment conducive to that type of cooperation. One practitioner who might be expected to work with physicians in an integrative way worked in the family medicine clinic associated with the medical school. However, his interactions with physicians seemed to be limited; working with them involved only referring patients to one another. Others argued that practicing with physicians would be ideal; one acupuncturist trained in China missed the communication common in the hospital in which he worked before coming to the United States. With blood work, test results and X-rays, he felt like he would be able to better treat his patients. Unfortunately, patients rarely bring these materials (nor do all physicians want to give them out, nor do all acupuncturists want them). Often, however, rather than blame the patients, LAcs implied or stated that MDs did not want to work with them.

> When a referral is made, it's pretty impersonal. There's not a phone call from the doctor, saying, "I'm sending so-and-so over." The person just shows up with a script from the doctor or saying, "I came from Dr. So-and-so; they had your literature and so here I am. Tell me about acupuncture." I'm not getting a breakdown of the person's history from the doctor, or a heads-up… I don't think there are that many physicians out there trumpeting my name, or necessarily any acupuncturists' name, as something in an active way. But because I feel it's becoming more and more of an asked question by patients, then … [physicians feel they] need to have a resource [for the patients]. (Paul, LAc)

One of the acupuncturists who had done an internship in a community health clinic and who had regular contact with physicians still lamented the dearth of true cooperation. She explained:

> I could tell, when you're sitting there, and you're an MD, and somebody's sitting in front of you, and their problem isn't changing, and they've had five years of chronic fatigue, and here's the list of symptoms that are getting worse—it's nice to be able to say, "Well, maybe we'll tweak this medication for you, and then also, make sure you keep on coming to see the acupuncturists on Mondays, because you know how that helps you with your back pain" or whatever—that you have something to say rather than "We can't do anything for your back pain." So I felt like it was good in that way, and they liked us, and it felt good. But it didn't feel like it was necessarily collaboration. It was just—they knew what we could do, and we knew what they did, and we talked to each other about it, but then it is really apples and oranges. Like, they can't tell us anything about how to treat, because they don't really know what we're doing. (Erin, LAc)

For their part, all MDs had regular and frequent contact with other MDs, as mentioned above. Most of the MDs blamed the lack of communication on the LAcs. In fact, they argued, they would love to work more closely with acupuncturists and felt that, at least to a certain extent, they would like to learn more about acupuncture.[10,11] In this regard, MDAs occupied a middle ground; as a group, they were more likely to maintain follow-up contact with referring physicians, and they often worked in tandem

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[10] This likely reflects the self-selection of study participants, who may have participated in order to learn more about it. In fact, several physicians asked me to explain components of the theory and practice of acupuncture after the interviews ended.

[11] Symbolically, this lack of communication may also make acupuncture seem more mysterious and esoteric and less *factual* and *scientifically based*.

with clinical partners, who were almost always based in Western medicine. The next quote illustrates this.

> We send a letter when they first come in with a general plan as to what our treatment protocol will be, and then a significant portion of the time, we'll either send updates or if they've dropped out of treatment, occasionally we'll say, you know, "After three treatments, [or after four treatments,] the patient had no improvement with acupuncture and they're discontinuing treatment." […Thereafter] I don't really know; I just assume people seek medical care or alternative medical care, until they find something that works for them." (Rachel, MDA)

Integrative healthcare requires cooperation and communication among healthcare providers. In general, MDAs have developed networks with other physicians, and are therefore more likely to communicate with physicians, indicating a more integrative approach. Non-integrative practitioners' communication and cooperation are hindered by other components of social boundaries (task differentiation and spatial separation), which in turn help maintain social boundaries. Integrative practitioners, or those fluent in both languages, so to speak, are more able to communicate with different types of practitioners, the extent to which this actually occurs depending largely on the individual practitioners. Calliope is a licensed acupuncturist and registered nurse. When asked, she pointed out that she was motivated to seek more training and certification in conventional medicine both for the legitimacy it provides and to enable her to speak the same language as patients and physicians. She was quick to note that her training verified what she already knew, and was important almost exclusively because it facilitated communication and cooperation by providing a common language and conferring upon her the legitimacy that accompanies conventional medical certification.

Summary: Social Boundaries

Following Shuval and Mizrachi (2004), I conceptualize social boundary work as consisting of task differentiation, lack of cooperation and communication, and spatial separation. My hypotheses hold that integrative acupuncturists and integrative physicians would maintain relatively weak social boundaries between their practices, while non-integrative acupuncturists and physicians would draw relatively strong social boundaries.

On the whole, the interviews confirmed these expectations. Integrative practitioners, both physicians and acupuncturists, who worked closely together professionally, were often located closer together spatially and geographically. They spoke with each other more frequently and cooperated more openly. Thus, the social boundaries were weak between these two groups. Additionally, physicians and acupuncturists who worked together frequently seemed more confident about the different strengths and specific contributions each could potentially make in the healing process. They revealed a clear understanding and acceptance of task differentiation between acupuncture and conventional medicine than non-integrative practitioners, thus maintaining relatively strong social boundaries in this respect. Medical acupuncturists' social boundaries tended to be relatively weak, which makes sense in light of the fact that they are both integrative physicians *and* integrative acupuncturists at the same time.

Strong social boundaries reflect the attempt to maintain professional dominance (by non-integrative physicians) or claim a particular niche market or healthcare type (by non-integrative acupuncturists). Social boundaries are weakened by the integration of the two types of healthcare practitioners (acupuncture and conventional medicine).

Working together weakens social boundaries between acupuncturists and physicians, either by necessity (spatial) or through exposure, discussion, or understanding (task differentiation and cooperation).

SYMBOLIC BOUNDARIES

Symbolic boundaries are maintained not by physical distinction, but by perceptions of how these two groups of people or practices are different ideologically.

I hypothesized that integrative physicians would draw stronger symbolic boundaries than integrative acupuncturists in the face of weakening social boundaries (H2). Results regarding medical acupuncturists complicated this hypothesis somewhat. Symbolic boundaries maintained by medical acupuncturists were definitely less prominent than those maintained by physicians who had no contact with acupuncturists other than patient referrals. I also hypothesized that compared to integrative acupuncturists, non-integrative acupuncturists would draw stronger symbolic boundaries between acupuncture and biomedicine (H3). Licensed acupuncturists did indeed maintain stronger symbolic boundaries than medical acupuncturists.

Practitioners often emphasized ideological distinctions between healthcare paradigms. These distinctions are often similar to legitimating claims (see below) but differ slightly from the cognitive, moral, and pragmatic claims they make. Symbolic boundary work refer to contrasts between the two paradigms: "This is the way *our* practice *differs from theirs*." The work of the CAM social movement (and earlier, the move toward dominance by conventional medical practitioners) has reinforced these contrasting expectations as part of the collective identity of the practitioners. For example, although certainly not a unanimous declaration, several LAc expressed

skepticism about the claims of chiropractors, with one saying that most chiropractors "aren't worth their salt" (Adrian, LAc). This same acupuncturist praised osteopathic doctors highly and said that he'd love to work with them.

Many LAcs also contrasted their practices with MDs, commonly in terms of the amount of time spent with patients. This is a practical consideration (see pragmatic legitimating claims below), but also a symbolic one. Specifically, many acupuncturists were quick to point out that they felt most doctors' hearts were in the right place, but that practical considerations and organizational pressures (coming from insurance and pharmaceutical companies) took away from their ability to provide the best care possible to their patients. Of course, in doing so, and by setting themselves apart from doctors and companies, these LAcs indirectly portray themselves symbolically as above such mundane pressures and more single-mindedly devoted to healing. While not explicitly accusing physicians of holding back or not caring as much for their patients' health, the acupuncturist quoted below argues that, while conventional medicine does indeed serve an important purpose in healing, Chinese medicine goes further.

> Even talking to my MDs that I treat, they talk about being frustrated that they feel like their medicine has been reduced to just prescribing medication. So, the one woman I treat who sees about 50 clients a day, that's another difference: she sees 50 clients a day, and I see like thirty in a week. I spend an hour with everybody, and … [with MDs} it probably varies from practice to practice, but it's just a way shorter amount of time. … And then the other thing is that I feel like, unfortunately, often, Western medicine is treating symptoms and not cause, and I think that theoretically, acupuncture is treating more cause. … I sometimes get into a symptom thing, but I think my medicine has much more room for treating cause and corrective kinds of treatment than I think Western medicine does. (Erin, LAc)

Since MDAs are also physicians, I was not surprised that they were generally less likely to contrast themselves symbolically with conventional physicians according to the amount of time spent with patients. Instead, they frequently portrayed their practices as

more complete in that they could use acupuncture to treat conditions that were either non-responsive to or inappropriate for conventional treatment. They also frequently contrasted their practice with LAcs by stressing their stronger background in (conventional) "science." While most MDAs acknowledged that LAcs might indeed have a deeper understanding of acupuncture and TCM, these MDAs asserted that their own practices were not inferior since they have command of both approaches. Some MDAs suggested that what they do not understand from a TCM perspective, they are able to understand through "science."

Many healthcare practitioners described the two modalities (Western vs. TCM) in quite different terms, adding to the symbolic distance between them. For example, the following MDA was trying to explain what makes acupuncture different from more conventional treatments:

> Chinese medicine … is a completely different field of medicine than Western medicine. … [It] has its whole other philosophy, it has a whole other way of thinking about the body, in terms of energy, in terms of the seasons, in terms of meridians. … [It's] a completely different way of looking at illness. I mean the spleen qi, the liver qi … it is and it's not compatible with [conventional] medicine, because a Chinese medicine practitioner might not integrate any of [conventional] medicine…. Whereas [a Medical acupuncturist] could think about it as an adjunct. … And I don't need to necessarily know, you know, all the details of the Chinese medicine behind it …. But I do see it as very different, because … from what I know about it, Chinese medicine just has a completely different view on what causes illness. (Sarah, MD)

MDs' concerns about acupuncture and Chinese medicine were often stated in practical terms. More often than not, they described herbs as dangerous and questioned all evidence in support of acupuncture (and even evidence of its ineffectiveness) based on procedural standardization or scientific methodology. MDs were often skeptical of the inability of "acupuncture" to present standardized treatment regimens for every patient, in the way that conventional treatment generally does (Kaptchuk 2000).

Methodologically, double-blind tests are impossible with acupuncture, the sample sizes are often very small, and treatments are often not sufficiently detailed to make replication possible. As scientists trained in conventional treatments and methodologies, this causes great unease among MDs.

I also found a sense among MDs that their authority is being challenged and their knowledge questioned. The following quote is illustrative:

> [C]ertainly in the past, doctors were seen as the authority figure; were not to be questioned, … and that has changed dramatically since I finished my medical training, to the point where people say,… "you're [just] a technician," almost … and I think that sense that the physician is omniscient just doesn't exist anymore. (Kimberly, MD)

As the symbol of "physician" is losing authority, products and practices labeled as "natural" were attaining a new level of favorability. For example, Isaac (MD) explains his exasperation at patients' inclination to trust "natural" or "herbal" products as safe without proof.

> [There is the assumption that n]atural or herbal is safe. You know, unless you prove otherwise. … I mean I'm sure cost has something to do with it; people don't have any healthcare, if they can do something cheaper... But that's not discounting what is available; I just think we probably should get more information from non-conventional ways to do things. (Isaac, MD)

Many MDs, like Isaac, conveyed a feeling of worry for the patients; they considered it their responsibility to look after the health of their patients, who often were – frustratingly – not paying attention.

MDs did not often portray acupuncture itself as dangerous; however, herbs were potentially harmful. Some MDs worried that patients would take herbs under the assumptions that "natural" substances must be safe and that they need not inform their physicians when taking them. In the physicians' view, herbs could interfere with the success of conventional treatment, and some MDs were resentful of this practice. In

addition, these MDs feared that herbs might be contaminated and that herbalists might lack sufficient training to dispense them appropriately. Herbs, seen as "natural," were not critically assessed by patients, and several MDs expressed concern about patients who associated acupuncture with "natural" and therefore good, when MDs clearly felt as if the association of CAM with nature was often misleading to patients.[12] Practitioners used certain aspects of the "other" practices to convey differences; these differences were frequently great significance by the practitioners.

Locations

Differences in perceptions of ideological differences were also conveyed by symbols located within the spaces occupied by the practitioners. Physical locations help maintain symbolic boundaries. Among those I interviewed, three physical features gave visitors or patients symbolic cues about the type of practice they were visiting: location and type of building, type of reception area, and office or treatment room.

The offices of acupuncturists were frequently houses converted into offices, and many shared space with massage therapists, chiropractors, or counselors. As I mentioned above, only two (out of 11 total practices) were located near hospitals. By contrast, only one physician was in a building not near a hospital or in a clinical area (surrounded by healthcare centers and clinics). This physician shared space with a licensed acupuncturist in a converted house.

Buildings containing doctors' offices generally "felt" conventionally medical. On entering, I was usually met with a reception desk, a waiting area with chairs, couches,

[12] As it happens, Paul (LAc), who was trained in herbal formulas and used them frequently, expressed a very similar concern.

and tables, stacks of general reading materials and pamphlets about pharmaceuticals and treatment options, and so on. Often, nurses and other physicians walked through the halls, and the receptionists generally were wearing nursing scrubs.

On the other hand, licensed acupuncturists generally maintained reception areas with new-age or high-end consumer magazines, often using candles or incense that create a more exotic and "relaxing" atmosphere. One licensed acupuncturist who worked in a family medicine clinic shared a reception area with the rest of the family medicine clinic, which was decorated like the other MD reception areas. However, his treatment room, although very much like a conventional medical treatment room, was decorated in a way that hinted at non-conventional treatment.

Decorations were consistently used to support symbolic boundaries. All acupuncturists' offices, whether medical or licensed, were decorated to some extent with symbols of Chinese medicine, both technical and cultural. Technical markers frequently took the form of framed certificates, posters with diagrams of meridian channels, scale models of human bodies marked with meridians, posters indicating auricular (ear) meridians, and the like. Additionally, acupuncture treatment rooms often contained candles and radios; music is generally played during treatment. Cultural markers, on the other hand, generally reflected Chinese culture or a more ambiguous "Asian" culture. For example, Jamie, who practices Japanese acupuncture, has a Japanese "lucky cat" statue in her reception hall, and she goes to Japan every year to study with a particular teacher. Thus, the Japanese markers reflected her interest in Japanese culture and her practice of Japanese acupuncture. Frequently, artwork depicted generic Asian places, people, and styles (e.g., scroll art, Chinese brush paintings, Japanese landscapes). Treatment rooms commonly had framed Chinese or Japanese calligraphy. Given that

most of the practitioners were not Asian or Asian-American, one can assume this choice was symbolic boundary-marking.

On the contrary, the offices of physicians were generally decorated more plainly, with framed diplomas and reference books. At best, their decorative individual touches were such conventional items as family photos or memorabilia (e.g., sports teams photos and gag gifts). Aaron (MD), who practiced with Rick (LAc) burned incense and had candles around the practice. Highlighting the infrequency of such decorations, Rick pointed out to me that those were not his items, but that patients always assumed they were his.

Summary: Symbolic Boundaries

Symbolic boundaries are distinctions of an ideological or symbolic nature between types of practices. I expected them to be weakest between integrative acupuncturists and other practitioners because newer professions have less to lose by associating with established professions. Established professions - physicians in this case - have the most to lose from doing so. For this reason, I expected physicians to draw relatively strong symbolic boundaries. I also expected non-integrative acupuncturists to maintain strong symbolic boundaries in order to highlight innovation and uniqueness, and emphasize the ways in which they exceed the capabilities of more conventional healing techniques.

My interview data indicate that, as expected, non-integrative physicians characterized acupuncture as completely different in nature and approach from conventional medicine. Integrative physicians maintained strong symbolic boundaries as well; many medical acupuncturists, for example, distinguished their acupuncture

treatment rooms from conventional treatment rooms with acupuncture-specific anatomical diagrams and included unconventional practices in their treatment of patients, such as playing music or burning candles or incense. However, in many ways symbolic boundaries were still weaker for this group than for non-integrative acupuncturists, whose offices and treatment rooms were usually distinguished not only by symbols of acupuncture, but also by symbols of Chinese or Japanese culture. Such symbols clearly set apart their healing processes from conventional modalities.

The results for these hypotheses are less clear than for social boundaries, however, primarily because the practitioner categories themselves were less distinct than anticipated. Nevertheless, these symbolic boundaries are very important to the healthcare practitioners who participated in this study. Further, the interviews revealed that integrative acupuncturists expressed the weakest boundaries, in line with H1 and H2b.

BOUNDARIES IN ACTION: A CASE STUDY

Upon arriving for the interviews, I was almost always met by the licensed acupuncturists in person and led into a treatment room for the interview. On the other hand, in physicians' offices I was always greeted by receptionists and asked to wait in the patient waiting room (although slightly more than half of the physicians chose to be interviewed over the telephone). Beyond this striking difference, the practices displayed more subtle evidence of symbolic and social boundaries, such as the "Asian" art frequently displayed in the practices of LAcs and described above. The following case study will allow me to go into more detail about the boundary work of one specific

practitioner. As a licensed acupuncturist who works in a conventional medical clinic, Yuan provides many examples of boundary work, both social and symbolic.

Working together, working apart: Yuan, LAc

Many acupuncture practices were in converted houses, while others were in more industrial or clinical settings, often near hospitals. Even in the latter cases, however, spatial separation was maintained, as shown by the case with Yuan, a LAc who works with physicians in a health center under the purview of a local medical school. Yuan also has a PhD and teaches pharmacology at the medical school. He keeps up with advances in the journal of the American Academy of Medical Acupuncture. Although not a medical acupuncturist, which requires a medical degree, he frequently attends professional meetings with medical acupuncturists. He is permitted to do so because of his position in a medical school and because he regularly conducts medical research.

When asked about his decision to work in the medical school environment, rather than in private practice, he explained that, in addition to getting referrals from physicians, he also enjoys the feeling of working in a "community." In fact, the interview in his office (one of the few offices of acupuncturists that I saw) resembled a small community: two residents joined us for quite some time, working on the computer or calling patients during a large part of the interview.

Being in such close proximity to physicians encourages communication with physicians and physicians-in-training. He explained:

> The physicians know that what I'm doing and also, if they have some problem, and if they want to try it, and then they also do that. So, they understand, and also I give a lecture... Because this is a family medicine department, and they practice family medicine, [this year] two residents rotated with me...

These physicians were able to communicate with Yuan when they had questions about how acupuncture works or wanted to try it out themselves (several physicians in my study noted that they would not want to refer a patient to an acupuncturist without having undergone the procedure themselves). Also, in Yuan's view the physicians-in-training were able to begin their careers with a relatively unbiased view of acupuncture, learning what it can and cannot do, which presumably would allow them to be comfortable making more informed decisions about referrals to acupuncture.

While social boundaries in Yuan's practice were relatively weak, symbolic boundaries were clearly demarcated. At one point during our interview, Yuan informed me that he needed to go check on a patient. He invited me to observe (after getting permission from the patient) and I was struck by how different the room was from other acupuncturists' treatment rooms. As I noted in my field notes:

> The small treatment room was unlike the others I had seen to this point in several main ways. As it was part of a family medicine clinic, it looked more like a room you would wait in to see a general practitioner, with a grey-flecked white tile floor, white cabinets, boxes of plastic gloves on the counter, and a Lunesta clock hanging on the wall. The glare of a fluorescent light caught on the bright white of the paper covering the bed, and the practitioner even wore a white jacket, just like the doctors and residents working there. A few things made it different from "any other" doctor's office, though, aside from the needles: 1) charts on the wall depicted not only his certificates in acupuncture, but also acupuncture points on the body, and on the ear separately, 2) the table covered in paper is actually a massage table upon closer inspection, and 3) a Chinese calendar and plastic figurine with the meridians marked sat out on the counter alongside the boxes of rubber gloves worn by the acupuncturist (no others I noticed wore rubber gloves). [As he left, he turned on a small radio, which] played relaxing music while the needles were in, and he lit a few candles and turned on a small lamp. [Before he left, the woman appeared to be thoroughly enjoying her treatment, although she had been worried about it at the outset.] In many ways this was the same [as other acupuncture treatment rooms], but in many ways [it was] starkly different.

In cases such as this, since social boundaries are arguably weaker, one might argue that symbolic boundaries such as these are even more crucial. There must be some way of distinguishing the two types of practices, especially if Yuan is going to continue to argue that acupuncture has unique benefits not possible through the conventional treatment offered by others in his clinical setting. On a larger scale, making this kind of distinction positively impacts the amount of legitimacy and professional sovereignty of Chinese Medicine. I will discuss legitimacy in more detail in the next chapter.

DISCUSSION

In retrospect, it is likely that their training makes health practitioners more willing to overlook boundaries between types of healthcare modalities. LAcs must learn to operate within a healthcare system based on physician dominance, and for their part, physicians learn in school and through continuing education that patients are becoming increasingly concerned with "holistic" care and are more willing and likely to seek alternative or complementary medical treatments. They also realize that these treatments can interfere with their own (conventional) treatments, and many feel motivated to understand them and be open to them as much as possible in order to provide the best (and most informed) care to their patients.

Almost all of the MDs interviewed would at least consider referring to an acupuncturist if the patient requested it. Although they do have doubts about many of the claims made by acupuncturists, they generally felt it could be helpful (except for herbal treatments). They still tended to argue that conventional medicine was the main cause of improvement, with acupuncture performing a secondary role, through the relief of symptoms, for example. Thus boundaries were maintained between the groups,

less by acupuncturists than by physicians, who seemed to have the upper hand in whether or not cooperation was attempted or maintained.

Conventional medical practitioners were rather accommodating to patients who attempted to learn more about acupuncture, even more so if they had worked with CAM practitioners in the past or had experience with it as patient themselves. Those who were less accepting of CAM practices understandably maintained stronger social and symbolic boundaries than those who were more accepting of it.

Although acupuncturists, as I expected, maintained strong social boundaries, many of them did so unwillingly. They would have preferred to work with physicians, but communication difficulties prevented it. Symbolic boundaries, as I expected, were strongest between non-integrative practitioners.

Medical acupuncturists devote much time, effort, and expense to training in a modality many of their colleagues do not fully support. It is clear that they are convinced of acupuncture's potential benefits, as evidenced by their general willingness to refer to a LAc if they believed the patient was a good candidate despite their own lack of success in treating them with acupuncture. They understood that there were certain things the LAc provided that they could not offer in their own practices. In fact, Aaron (MD) had taken the Helms course at UCLA (probably the most common training program for MDAs) but chose not to offer acupuncture because he felt he could not practice *both* acupuncture *and* conventional medicine to their full potential; he chose instead to hire Rick, a LAc, to work with him in his practice.

While there was often cooperation between MDAs and LAcs, there were also boundaries drawn between them. For example, several LAcs suggested that MDAs treated patients primarily symptomatically. Contrary to this belief, the medical

acupuncturists were all familiar with Chinese diagnostic treatments and believed that they could help explain "mysterious" conditions.

Most LAcs maintained strong social boundaries; exceptions include Yuan, whose situation is described in the case study above, and two other LAcs who work fairly frequently with the chiropractors in their offices, often discussing patients' health and progress with them. When acupuncturists work "with" physicians, they are utilized in what might be seen as an "outsourced" way, for support of conventional methods (e.g., helping support conventional infertility treatments or relieve symptoms of cancer treatment). As a result, even among "integrative" practitioners, relatively strong (not weak, at least) social boundaries were maintained.

In the next chapter, I discuss findings relative to my second set of hypotheses: those regarding legitimating claims. While analytically the concepts of boundary work and legitimating claims are distinct, I expected that practitioners might use legitimating claims in symbolic boundary work; to a certain extent legitimating claims about one's own practice may serve to distinguish it from other competing professional or occupational groups. These legitimating claims were commonly used by all practitioners, although in different ways, and did serve to reinforce symbolic boundaries. In the next chapter, I will go into detail about how.

Chapter Six: Legitimating Claims
Cognitive, Moral, and Pragmatic

In this chapter I turn to my next principal concern in this study: legitimating claims. Legitimacy, in a general sense, is often defined as taken-for-grantedness. However, as any member of a marginalized medical practice will attest, this definition falls far short of adequately conveying the struggle healing practices and practitioners must overcome in order to attain it. Important components of this struggle are legitimating claims, or statements made about a healing modality's appropriateness and worth. As I expected, physicians, licensed acupuncturists, and medical acupuncturists all used legitimating claims to legitimate or delegitimate acupuncture.

Following Johnson et al (2006), I proposed two main categories of legitimating claims would be used: cognitive and moral. Cognitive legitimation is likely to occur in two forms. The first is sense-making, or explaining the unconventional treatment in conventional terms. The second is comparison to and support by legitimated others. Specifically, I expected to hear references to the safety of a particular treatment, strengthened by publication in a legitimate medical journal or inclusion in the curricula of legitimate medical schools.

On the other hand, moral legitimating claims are "sociotropic" (Suchman 1995: 579), meaning that judgments of legitimacy are based upon "whether the activity is 'the right thing to do,' [which] in turn, usually reflect beliefs about whether the activity effectively promotes societal welfare, as defined by the audience's socially constructed value system." If a healing modality is considered by most to be good for patients, its practitioners normally would have considerable autonomy. Additionally, I expected non-integrative licensed acupuncturists to use arguments about conventional medicine

as dehumanizing and potentially polluting to the body. In a society highly concerned with individual rights, and increasingly with "holistic" treatment, claims such as these could potentially weaken arguments about the moral legitimacy of a particular healing modality. Specific hypotheses are listed in the table below.

Table 6: Hypotheses: Legitimating Claims

	Acupuncturists	**Physicians**
Integrative	**Cognitive**: - efficacy, safety of acupuncture; legitimate biomedical studies - sense making: acupuncture in biomedical terms **Moral**: - acupuncture does not need biomedical supervision to safeguard the interests of patients	**Cognitive**: - efficacy, safety of acupuncture; legitimate biomedical studies - sense making: acupuncture in biomedical terms **Moral**: - acupuncture should be monitored by physicians in order to protect the interest of patients
Non-Integrative	**Cognitive**: - efficacy, safety of acupuncture; historical and anecdotal evidence - sufficiency of acupuncture; - historical and anecdotal evidence **Moral**: - biomedicine is dehumanizing - biomedicine is fraught with malpractice, corruption, invasiveness -acupuncture is better without biomedical interference	**Cognitive**: - sufficiency of biomedicine - problems with CAM (lack of standardization in training and practice, inefficacy **Moral**: - acupuncture should be monitored by physicians in order to protect the interest of patients

Hypothesis 4a*:* Integrative practitioners, more so than non-integrative practitioners, will emphasize compatibility with biomedical views of health, healing, and science, as a way of sensemaking, drawing similarities between the two.

Hypothesis 4b*:* Non-integrative acupuncturists, more so that integrative acupuncturists, will emphasize historical background or longevity as a form of sensemaking more than integrative acupuncturists.

Hypothesis 5*:* Integrative practitioners will rely on legitimate others, in this case legitimate "scientific" studies.

Hypothesis 6a: Non-integrative acupuncturists will highlight problems with the biomedical approach to healing, such as its limited focus on cure rather than care, and the dehumanization of patients, in order to highlight the value of their own paradigm.

Hypothesis 6b: Non-integrative acupuncturists will highlight problems with biomedicine, such as incidents of malpractice, corruption, invasiveness of the procedures, in order to highlight the value of their own paradigm.

Hypothesis 7a: All acupuncturists will argue in favor of their own autonomy, claiming that acupuncture can be successful as a stand-alone practice, and that

acupuncturists are capable of operating without the supervision of a biomedical physician.

Hypothesis 7b: All physicians will argue against the autonomy of acupuncture, claiming that acupuncture should be practiced by or under the supervision (or at the very least, with the consultation) of a licensed biomedical physician.

In line with my hypotheses, legitimating claims made by physicians, acupuncturists, and medical acupuncturists were both cognitive and moral. In addition to the two expected categories of legitimating claims, a third category, pragmatic claims, emerged during the course of the study. Differences in the types of legitimating claims used by each group of actors were not as pronounced as I expected; all claims, to differing extents, allowed for the possibility of acupuncture as a rational and appropriate treatment option. The importance of the emergent category of pragmatic legitimating claims was surprising initially, but is easily understood in the current "medical marketplace" where healthcare consumers are looking to make the smartest purchases they can, and healthcare services are commodities, whose practitioners are generally in fierce competition for purchasers.

I will now present detailed findings in line with my hypotheses about cognitive and moral legitimating claims. After I do, I will describe the emergent category of pragmatic legitimating claims used by practitioners in my study. As in the previous chapter, quotes are identified by the practitioners' names and type of practice (Appendix 7).

COGNITIVE LEGITIMATING CLAIMS

Most licensed acupuncturists were capable of and ready to translate the mechanisms by which Chinese medicine works for patients. However, they also frequently point out that patients most often are not interested. Many of the more skeptical patients come to acupuncture as a last resort, so they are not really curious

about anything other than "Will it work, or will I have to take more drastic steps (such as surgery) with my physician?"

Nevertheless, the licensed acupuncturists were ready with explanations, should they be requested. When explaining acupuncture, LAcs often portray acupuncture in biomedical terms, often in order to facilitate the understanding and comfort of people experiencing an unfamiliar modality. Patients are comforted, LAcs imply, because this unfamiliar practice can be translated into familiar (even if not well understood) and legitimate conventional medical terms. For example, the explanation of *qi* below reflects the way one LAc usually explains acupuncture if asked:

> The … overarching philosophy of Chinese Medicine is that if everything is flowing, unobstructed, throughout the body, as far as *qi* is concerned, a person cannot have a symptom of any kind. The problem is, through a variety of conditions—genetics, trauma, stress, diet, gravity, all of the above—there are blockages somewhere. I also try to demystify the idea or concept of *qi* [for patients], because again, we're not really familiar culturally in the West with that, and the best way … to do that, is to point out to people that at any given second in our lives there are millions if not billions of cellular processes going on. … The doing of those processes …, that's *qi*. What's kind of, in a sterile way, called "involuntary processes," in Western Medicine science. That term doesn't take away from the fact that it's a fairly amazing, complex process that's going on every second of our lives…. That's *qi*. There's also a lot of other ways: it's DNA, it's life, when a leaf falls off a tree because it's brown and died, its *qi* has gone. When it was green, it was full of *qi*. (Paul, LAc)

When I asked if he learned this in school, the acupuncturist explained that for the most part, many discoveries regarding the mechanisms behind Chinese medicine (and therefore acupuncture) were relatively recent. He continued, "They probably started doing those studies when I was in school, so the demystifying idea of *qi*—that's not really the way it's taught. I mean, it's pretty much said, '*Qi* is *qi*. It's energy. Deal with it. It's a fact.'" In this case, he implies that the "facts" and "evidence" presented as part of his education were (at least at that time) incomplete without conventional scientific

explanations, further implying that true understanding of the mechanisms through which Chinese medicine works will be discovered through (Western) scientific methods, and only through these methods.

Evidently, Western practitioners can come to "understand" Chinese medicine in Western terms, thus better understanding, and explaining, the mechanisms by which it works. While not all schools necessarily emphasize the importance of this translation, it is very important for some patients and is a crucial aspect of the "mainstreaming" of CAM modalities such as acupuncture. In many ways, translation normalizes the "unusual" practice and makes it acceptable, and safe, to seek out alternative therapies. As Paul put it,

> [P]eople hear the word *qi* is translated, or loosely defined, as energy, then you can get some people with eyerolls. "Oh, energy, that's some new-age stuff" and so it needs to be made relevant for them. It's not me lessening my own appreciation or understanding of what *qi* is by giving the Western definition, it's just that we live in the West. So, somebody is making the—often times, for them, a—huge step to being open to something like this, then I need to meet them halfway: let them know, you're not weird, there is something to this.

These Western explanations show, as Paul puts it, that "there is something to [acupuncture]." Otherwise, the implication is that patients would not turn to it. LAcs I spoke with who graduated more recently than Paul were more assertive that their educations included conventional explanations of acupuncture. For example, Will went to a school that, in his opinion, did not spend ample time on anatomy and physiology; nevertheless he felt comfortable about having chosen that school because he had worked several years as an EMT. Most acupuncturists learned conventional explanations for acupuncture in the course of their schooling, but having the ability to explain acupuncture in conventional terms was important to all acupuncturists whether it was learned in school or not.

To an even greater degree, medical acupuncturists felt that their practice embodied the best of both worlds. In training, they were taught about meridians and other TCM-specific healing theories, and they said they would tell their patients about them if asked. However, since patients often tried acupuncture as a last resort, they would often simply accept acupuncture as part of ongoing treatments, not trying to understand the way it worked. Whether or not the patients ask, however, the medical acupuncturists have a certain understanding of TCM, which in most cases, has been translated into "medical acupuncture," a term for the practice of acupuncture by physicians initially taught at the Helms Medical Institute sponsored by UCLA. Most of the medical acupuncturists I spoke with received their training through a program at UCLA designed by Joseph Helms; the website for the Helms Medical Institute claims that 90% of medical acupuncturists in the United States came through this program (Helms Medical Institute). A description of his website explains the medical acupuncture training program as follows:

> The program is comprehensive in that its teaching content is not restricted to one school of acupuncture theory and practice. The teaching approach is grounded in contemporary western medicine and bioscience, yet addresses the full tradition of acupuncture as derived from classical Asian texts. All major disciplines of acupuncture that have practical clinical value are represented in the program, from pragmatic neuroanatomical treatments for chronic pain to elegant energetic treatments for functional and internal medicine problems (Medical Acupuncture for Physicians).

Medical acupuncture is explained as acupuncture liberated from restrictions stemming from "acupuncture theory and practice." In interviews, MDAs talk about scientific evidence for acupuncture; however, they occasionally also mention the long history of acupuncture, connecting a new form of practice to an old tradition.

The advantage of medical acupuncture is frequently attributed to the ability of MDAs to "speak both languages." Compare the following quote with the one from Paul above:

> I try to use layman's terms and just to help them understand the basic idea of acupuncture, and then give them some examples, because the theory behind it is very complicated, and you don't want to confuse people…. I try to use very simple terminology. Most of them understand very well. Like for instance, energy flow, …your body will create some pain killing agents naturally to kill the pain, and these sorts of things. … And most of them don't want to learn about science. … [S]ome of them even tell me that, you know, "I don't care. If it works, I don't care how it works." [laughs] (Hua, MDA)

Hua, like Paul, offers two ways of understanding to the patient, and like Paul, she often finds that patients do not really need to know how the treatments work as long as they work (see also Pragmatic Legitimacy below).

While patients are not generally concerned about conventional explanations for acupuncture, it is still crucial that practitioners are able to explain it in these terms. One medical acupuncturist, for example, has changed his diagnostic techniques because of difficulties in communicating with other physicians. Consider the following statement describing how the different TCM diagnostic system affects the way the MDA talks with MDs about shared patients:

> I don't think for the most part they care. They just want to know, is the patient improving or not improving? They don't want to know the specific Chinese diagnosis, and I don't use a Chinese diagnosis, to be honest. … I use … a neuromodulatory technique, which is really based on neuroanatomical, myotonical, dermatermal … techniques, which I can prove or is documented; there's science behind it. I can't prove how *qi* moves around the body. … [S]ome Chinese practitioners … feel pulses, and they tell you, "Oh, this pulse is low, and that's low, and the kidney energy or the liver energy, or the spleen energy…" I can't tell you that. … [F]or the first three or four years that I practiced, … I would make the Chinese diagnosis, but now it's more a neuroanatomical diagnosis for me. (Mark, MD)[13]

[13] When thinking about the small amount of communication between MDs and LAcs, it may be wise to consider the possibility that LAcs know doctors will not understand the notes, and so

Like Mark, most of the physicians I interviewed do not concern themselves with how acupuncture works. Instead, their primary concern is, "Does it work?" or "Will this help my treatments work (better)?" or "Is this a waste of my patients' money?" Thomas, for example, mentioned telling patients that the evidence is inconclusive about whether acupuncture works (infertility studies have given inconsistent results). MDs were concerned with alternative practitioners giving patients false hopes, but as long as it does not interfere with their own treatments, they seem to support acupuncture. As mentioned above, this is one of the main reasons they mistrust herbs; they are not closely regulated, and they are also more likely than acupuncture to influence the course of treatment, since herbs change the physiology of the body.[14]

Hearing about scientific evidence comforts MDs more than hearing about the "long history" of acupuncture. Kevin told me about a particular acupuncturist that he uses for referrals, explaining that he likes her because she gave a presentation at their practice in which she "spoke [his] language."[15] Part of the process of translating a practice into someone else's language involves linking it with already legitimate practices, such as studies in familiar (legitimate) medical journals, or well-known (legitimate) schools or hospitals. Thus, I also view this as a characteristic of cognitive legitimacy.

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decide not to send them. As physicians, MAs are used to getting notes from (other) specialists and so expect to send and receive them. They recognize that physicians frequently get notes they do not understand (e.g. from specialists). They, more than LAcs, recognize that physicians usually just want to know if the treatment working or not.

[14] This makes it seem as if they don't believe acupuncture in itself has such drastic effects. So does this take away from the perceived efficacy of the acupuncture treatment? Is it that the effects are always beneficial? What is that? Some seem to describe acupuncture as having (biomedically defined) effects on the body that are not necessarily what the acupuncturists says, but still positive (e.g. reduce negative effects of stress).

[15] He liked her so much that he left the interview to retrieve her contact information for me.

Most LAcs indicated that they paid close attention to acupuncture because it is included and discussed in (conventional) medical studies. They also noticed that it was being taught more frequently in medical schools and getting more exposure in popular culture. This attention to acupuncture in conventional scientific studies is important to the profession because it serves as an important indicator to outsiders and physicians that acupuncture indeed does work. This in turn makes physicians more comfortable referring to an acupuncturist.

The legitimacy associated with being included in conventional scientific studies present acupuncture as a healing modality that can complement conventional medical treatments; they also give physicians cause to consider acupuncture as better compared to other CAM modalities. Paul (LAc) explains:

> More medical schools in this country are offering at least a course in integrative, complementary, alternative medicine—so if somebody's exposed to it early on, and it has the legitimacy of the structure of medical school, then maybe they won't feel so strange by looking into it more. And then once they practice, being OK referring to it: they're not going to be looked on as weird. … There's a poll that came out in September of 2006 of almost 800 physicians … asking, of these 12 alternative modalities, two main questions: which one do you feel there's something to, legitimacy-wise, as far as effectiveness,[16] and the second part of it is, which of these 12 would you feel OK referring? And in answers to both questions, acupuncture was number one … [These were] physicians, and so they will have been aware of some of the journal and research from a Western point of view, so that gives some legitimacy to it.

Many other LAcs mentioned the importance of conventional scientific evidence in support of their claims about acupuncture. Most acupuncturists keep up with developing research by using web portals such as Acupuncture.com. In addition, several mentioned that they follow the research coming out of other legitimate, conventional scientific sources. Santi, originally from Japan, showed me a copy of one of the Japanese

[16] The implication that legitimacy and effectiveness are closely tied will be examined below (pragmatic legitimating claims).

medical journals that she regularly receives, which, she explained, publish more frequent but no less rigorous studies of acupuncture and Chinese Medicine than conventional American medical journals.

Medical acupuncturists also pay close attention to acupuncture studies in mainstream American medical journals, and many of them rely on the legitimacy of the Helms Medical Institute, explaining that they received their training at this well-known, long-standing school—the first of its kind in the United States. The inference is that if this school did not train effective medical acupuncturists, it would not still be around. This is similar to the argument about acupuncture given occasionally (but not as often as expected) that, if it did not work, it could not have persisted for so many years.

Medical acupuncturists explained acupuncture in conventional scientific terms and used evidence from conventional scientific sources. When asked about the extent to which his training extended into the Chinese diagnostic system, Rachel spent some time going back and forth between the two paradigms, conveying a certain type of "sense" she had made of the integration of the two medicines.

> [In Helms' text there are] three or four extensive chapters written about the scientific evidence for the existence of the meridians, for example, putting one point on the stomach channel on the face, which is right below the orbit at the center of the face, and stimulating that electrically, and then being able to pick up that electrical signal at the stomach channel on the leg. Which, these two points aren't typically connected by Western nerve connections, but because it's a path of least resistance from a Chinese medicine perspective, you can pick up that electrical signal on the stomach channel, but not two inches away on the gall bladder channel. … [There are] multiple ways that we can explain from a Western perspective how it works, you know. … I listened to all that, but in the end, I'm completely comfortable with the paradigm shift that's required. One looks at the body as a machine made up of parts that can be, that once they get sick, you can replace them, and that's great, because it makes heart transplants available to us and so forth. And then the Eastern philosophy is that the body's a garden, and needs to be tended, so if you do anything like gardening or cooking, you'll kind of know, if you add too much heat here, they'll get too black, scorched; if you have too much water in your rice it'll be too damp, you know.

> So, they use a lot of nature metaphors in Chinese medicine. I got real comfortable with that. (Rachel, MDA)

This quote illustrates the difficulties encountered in going back and forth – the "leap" MDAs must often make in order to make peace with both paradigms. Perhaps having the additional knowledge about TCM helps fill in some of the gaps left by conventional medical studies. MDs, for their part, often mentioned warning patients to watch for conflicting data about the healing potential of acupuncture, frequently explaining that until there is reliable data from acceptable sources, they will not be completely convinced its potential themselves.

Acupuncturists were challenged to prove the effectiveness of acupuncture treatment in general, and also to prove their fitness as individual practitioners, which they did by displaying certification such as framed diplomas and certificates. However, several MDs were unaware that certification for LAc even exists, much what qualifications are required to obtain it. Additionally, physicians have no frame of reference when evaluating the educational degree in acupuncture or Chinese Medicine. This may have exacerbated the commonly expressed skepticism about individual practitioners' differences; many MDs who referred patients to acupuncturists preferred doing so to specific acupuncturists that they had informally vetted through patient report or through an informal interview, usually conducted at the acupuncturist's instigation or request.[17] The quote below illustrates Kevin's thinking about referring to an acupuncturist, and how he would choose the practitioner:

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[17] Santi reported that a physician actually took the unusual step of coming to her office to find out more about her practice after several of her infertility patients got pregnant and attributed it partly to the acupuncture. Several patients saw the same acupuncturist because they were in an internet group for women dealing with infertility; one of the members became pregnant after receiving acupuncture treatments and informed the rest of the group.

> Most of the time what we're doing with alternative medicine is acupuncture. Because there's actually some pretty good data that acupuncture can augment some of the fertility treatments that we do. And there's a number of acupuncturists in you know, the metro Atlanta area that we've sort of developed a relationship with, just because often patients will go and seek out that type of treatment on their own and then come back to us, and once they tell us who they've been going to, and whether or not they've been happy with them, we start then also referring other patients to those same providers. We've actually had another provider also come out here, and give us a talk one day on their philosophy behind what they do, and it seems to be pretty in line with how we feel that patients should be treated so. (MD)

Physicians often rely on conventional studies to assure them that acupuncture is safe and can be helpful in a patient's treatment regimen. Additionally, they frequently refer patients to acupuncturists who have given an acceptable presentation to them or been favorably reviewed by other patients.

Several of the acupuncturists mentioned popular exposure as a factor in whether people tried acupuncture. They propose that seeing acupuncture in the popular press causes it to become a "normalized" option for them. Paul (LAc) explains:

> [People come in] who have seen it on Oprah, and "If Oprah allowed it, then maybe it's ok." There are a lot more news stories about it. [Once, after it was in the local newspaper,] I actually had a few [of] my own patients come in and mention that…. [Also, it] was on "Grey's Anatomy" … a few weeks ago; one of the doctor is getting needles in their face, and a physician was doing it, talking about his travels to the East, and studies over there, and that's what he was doing now. That reaches 25 million people on a weekly basis in this country. As opposed to 15 years ago, you wouldn't see that.

In addition to the example above, a few of the infertility specialists mentioned an episode of "Sex in the City" in which one character goes to an acupuncturist for fertility treatments after another character in the show has success with it. It is clear that this seems to be a cycle of cultural routinization or de-marginalization. In the same way that scientific studies serve as legitimate sources when physicians make sense of

acupuncture, the popular press might help acupuncture make sense to a potential patient (i.e. fit into a his or her realm of possibilities).

Summary: Cognitive Legitimating Claims

At the outset of this study, I predicted that integrative practitioners, more so than non-integrative practitioners, would emphasize acupuncture's compatibility with biomedical views of health, healing, and science, drawing similarities between the two. On the other hand, I expected that non-integrative acupuncturists, more so that integrative acupuncturists, would emphasize acupuncture's historical background or longevity, claiming that its value is demonstrated by its long period of development and practice (H4a and H4b).

Most of the acupuncturists did offer explanations of their practice in conventional medical terms. Several noted that these explanations were not available when they were in school, but that recent studies have helped illuminate some of the links to conventionally understood processes. However, most also acknowledged that conventional explanations are insufficient for all of the benefits of acupuncture or Chinese medicine. Acupuncturists also hinted that with continued study, conventional medical explanations will be found. Even acupuncturists with weak ties to physicians and other conventional medical institutions were familiar with conventional medical explanations of acupuncture. However, these practitioners tended to accept the truth and philosophy of Chinese Medicine, rather than rely on conventional explanations. Contrary to my expectation, however, practitioners rarely invoked acupuncture's history as cognitive legitimation.

I expected integrative practitioners to rely on legitimate others, particularly "scientific" studies (H5). In fact, almost all acupuncturists mentioned such studies. Some talked about them in ways that would justify and thus legitimate their own practice; usually, however, studies were mentioned in an offhand way, suggesting that the results were practically common knowledge. This familiarity, and the almost automatic mention of scientific research journals and schools, is likely due to the influence of their educational institutions and subsequent experience in the medical field, dominated as it is by conventional medical practitioners and institutions. As one might expect, this tendency was even more pronounced among medical acupuncturists.

MORAL LEGITIMATING CLAIMS

Cognitive legitimacy means that an activity is accepted as feasible and reasonable—it "makes sense" or fits into one's worldview. Moral legitimacy requires accepting that a certain course of action is "the right thing to do" or the way things ought to be. Moral legitimacy, therefore, is indicated when someone argues that a particular healthcare modality is "better" than another. I asked about the autonomy of acupuncture as one aspect of this issue, with the expectation that if acupuncture was recognized as the way healthcare "ought" to be practiced, its practitioners would have greater control over their own patients' treatment regimens.

According to respondents, Chinese Medicine is potentially a dangerous form of medicine, largely because it can interfere with the treatment regimens established by physicians. LAcs argue that they should have total control over their practices, since they have had the most training. Relying on an MD to tell a person Chinese Medicine is safe does not make sense to acupuncturists, who have invested much time and money

and energy perfecting their art and their science. Leaving it in the hands of MDs, who have little knowledge of it, clearly irked many LAcs. They felt that giving MDs this power does not make the public safer, as Paul (LAc) argues:

> I would hate to see herbs under the aegis only of MDs, who have basically very little working knowledge of what they do, as opposed to somebody who does—I think that's a dangerous area without specific recognition of somebody like me, who's studied it, been tested on it, and have used it for ten years.

Herbs, and Chinese Medicine in general, can be good for patients if practiced in the correct way. Acupuncturists are best suited to provide helpful care for their patients and thus should be able to make decisions in that regard that are not subject to physician approval. Claims such as these serve as moral legitimating claims, since they support the acupuncturists' stances that acupuncture can be helpful in treating patients.

Medical acupuncturists did not mention MD supervision of acupuncture. However, in an indirect way practicing medical acupuncture (as developed by Helms, at any rate) was in its own way a form of supervision. This form of acupuncture, as opposed to the many other types practiced by LAcs, was more standardized, predictable, and therefore appropriate. Also, most MDAs spoke of their acupuncture practices as treatments done in conjunction with conventional therapies. This implies that, as trained physicians, MDAs are better qualified to practice acupuncture – they are more capable of integrating the two types of treatments. Several LAcs mentioned concern with the ways in which some MDAs practiced acupuncture. Jamie explained:

> I think the medical acupuncturists, from what I've been able to ascertain, they get a very brief, basic, type of training. …From my experience [working in a practice with an MDA] if anyone was going to do anything dangerous, it was them. Because they have this confidence—over-confidence in some situations—from being an MD, that they can just do anything. Like for example, the MD at the practice where I used to work was doing something called cupping on the back of a patient … you use fire, a flame to get the cups going, and so she put it up here [gestures to her upper back] and it burned the patient's hair. And that's

> something that in acupuncture school, we are taught so many times, you don't do that. If you're going to do it, put it here [gestures lower], put oil on the back, and then slide it up. You don't burn a patient's hair, you know? Accidents can happen, but I've seen reckless things like that happen. That's just one example. There were many things like that—if anyone got injured at the practice I was in, it was from the MD. Not the licensed acupuncturists. (Jamie, LAc)

For their part, MDAs did feel that one aspect of Chinese Medicine that needed supervision: herbs. Many practitioners from all three groups (LAcs, MDs, MDAs) made this case. However, MDs who expressed concern tended to argue that herbs should not be used at all, since there was a danger of herb pollution, either due to unstandardized amounts because of unregulated packaging or actual pollution of the herb (by heavy metals, for instance) because of unregulated growing and harvesting. MDs also worried a great deal about the potential impact herbs would have on the pharmaceutical treatment regimens they had already begun with patients. On the other hand, LAcs often either suggested that herbs were fine in the hands of a trained LAc, or did not practice with herbs. When asked if he would recommend that his patients not take herbs, as many MDs did, Mark explains:

> Certainly I would tell them to be very -- to question significantly to make sure where these herbs come from, how they're sourced, and-you know the FDA doesn't control it, so they can make any claims they want!
>
> Interviewer: Who specifically?
>
> All the producers of herbs. And vitamins, and supplements. It's a non-controlled area. (Mark, MDA)

This gets to an issue of importance to all parties, the purity or corruption of medicine. There were very few instances of practitioners arguing that there was something wrong with conventional medicine. However, many acupuncturists argued that there system restrictions on physicians interfered with the goal of healing, such as insurance caps that limit how much treatment they can offer, or rapidly decreasing

reimbursements that cause physicians to reduce the time spent with each patient just to keep the practice running. Thus, factors beyond their control prevent many MDs from offering the kind of care they would like to give. Constraints on physicians related to organizational pressures from within the practice, a highly bureaucratized health insurance system, and a powerful pharmaceutical industry can at times be dehumanizing to patients. This dehumanization makes conventional medicine morally questionable, indirectly raising the status of the more humanizing Chinese Medicine:

> Overwhelmingly I feel like some of my clients have great doctors that they trust, but overwhelmingly they talk about not being able to have enough time to talk to their doctors. They want a sense of being able to explain to them the details, so that they can feel like the treatment—the way things are changing for them like medications or whatever—are really catered to them, and not getting boxed. (Erin, LAc)

Although LAcs almost always indicated that physicians were not to blame in general for many of the dehumanizing aspects of conventional medicine, they hold some physicians accountable for some problems. For example, Erin continues that in addition to the complaint of not having sufficient time with their physicians, other problems sometimes cause patients to seek out alternative treatments.

> There's definitely some complaints around bedside manner. … I have a friend who just went through med school, and I don't remember her ever telling me about like, how do you tell someone they're dying? So I mean, people come back to me with the most amazing comments. Like, "My doctor told me my infertility was a sinking ship." Like, who would—wouldn't you just say your fertility was "a challenging situation"? … She got pregnant and we were like "See?"(Erin, LAc)

LAcs also offer explanations of why acupuncture is simply better than conventional medicine, especially for certain conditions.

> To me … the overarching approach, philosophically, of Chinese Medicine, is that you do look at the individual as different. … You don't look at 10 people with high blood pressure and you give the same drug to all 10 people. It could be different herbal formulas, it could be different acupuncture points—there's so

> many different things that go into it. That's the beauty of it to me. Does it have more to offer because of that? Well, because of that, it's going to be better for chronic situations, because chronic problems have complex, multiple-layered, causative factors, not just what's going on physiologically. (Paul, LAc)

LAcs often followed statements of corruption or dehumanization of conventional medicine with exceptions for individual physicians, whom they did not think were at fault. They instead spent more time discussing all the good that acupuncture and Chinese Medicine could do for patients.

Instead of suggesting that either acupuncture or conventional medicine is better, or good, or bad, medical acupuncturists usually argued that using both practices in tandem achieved the optimum result. However, these practitioners occasionally revealed situations in which one approach outshone another. LuAnne, for instance, strongly asserted that other practitioners who might either refer out to CAM practitioners, or practice medical acupuncture themselves, were not "really" integrative, since they hadn't trained under integrative medicine pioneer and strong advocate Andrew Weil, which she had. Overall, however, respondents suggested that medical acupuncture was best positioned to meet the needs of patients more completely than either conventional or Chinese medicine. Mark, an anesthesiologist explains how he sought out training in acupuncture to fill a need in his own practice:

> When I was doing pain [management], and it hasn't changed a whole lot, there was a "slash-and-burn" attitude. You'd go in there, inject medications, and burn nerve endings, or cut them, or do something, and hope of getting some response… many times … the attempted treatment was worse [than the problem]. I just thought there might have been a better way to manage some of these patients, and that's what happened, probably 12, 14 years ago when I sought training in this. I must say, I kind of restrict my techniques I use for the most part, to … electrical nerve stimulation, which I understand because it has a Western, neuroanatomical basis to it. And it's a neuromodulating technique, and we can measure certain things, and so I think acupuncture in general, studying it, and the meridians and all that, is kind of like poetry to me: it's interesting, … but I think there's a lot to be proven in terms of what we already know. … (Mark, MDA)

In this sense, then, MDAs have more training, giving patients more options, and can tailor their use of both to their comfort level. Mark chooses to use primarily a method he can explain from the perspective of conventional medicine, and indicates the importance of scientific evidence for healthcare treatments, but his training has provided him with options not available to most MDs.

Summary: Moral Legitimating Claims

I expected non-integrative acupuncturists to highlight problems with the conventional medical approach to healing, such as its limited focus on cure rather than care and the dehumanization of patients, to legitimate their own paradigm (H6a). While I found that most acupuncturists did not specifically mention the dehumanizing aspects of medicine, they often emphasized their own willingness and ability to spend large amounts of time with patients, with the implication that they were able to treat the whole patient and see the larger picture of the patients' health.

I also expected non-integrative acupuncturists to highlight problems with the actual practice of conventional medicine, such as incidents of malpractice, corruption, and invasiveness of procedures, in contrast to their own paradigm (H6b). In fact, both acupuncturists and physicians pointed out problems with the practice of conventional medicine, most frequently the inability to spend sufficient time with patients.

On the issue of autonomy or supervision, I expected all acupuncturists, integrative or not, to argue in favor of their own autonomy, claiming that acupuncture can be successful as a stand-alone practice and that acupuncturists are capable of operating without the supervision of a conventional physician (H7a). Many acupuncturists expressed frustration about the current amount of supervision required.

At the time, to be licensed by the state, acupuncturists not already certified in another state were required to practice under the supervision of a physician for one year. This irked acupuncturists because the physicians often did not understand acupuncture at all. Therefore, it was seen as more of a bureaucratic hurdle than any sort of patient-protective measure.[18] Some also pointed out that medical acupuncturists, who completed only one-tenth the number of hours of training, faced no such mandate.

To be clear, acupuncturists supported the licensure process in general, seeing it as a necessary component for building a legitimate healthcare profession. Many even argued in favor of creating a separate certification process for herbs. Detractors warn that the use of herbal medicine is not only potentially dangerous, but is also potentially detrimental to conventional treatment regimens, and should only be administered by those who understand and appreciate the risks posed; there is currently is no certification process to delineate those who do from those who do not.

I expected all physicians, on the other hand, to argue against the autonomy of acupuncture, claiming that acupuncture should be practiced by or under the supervision of or in consultation with a licensed (conventional) physician (H7b). There was no strong evidence to support this hypothesis. Physicians seemed inclined to allow acupuncturists the freedom to practice as they see fit, admitting that they themselves do not understand acupuncture so they had to trust that acupuncturists know what they are doing. The limitations physicians seemed inclined to place on acupuncturists more often dealt with the range of conditions acupuncture was suited to treat, as discussed above.

[18] The requirements now require one year of supervision by a licensed acupuncturist (Official Code of Georgia Amended).

PRAGMATIC LEGITIMATING CLAIMS

The literature on legitimacy identifies two main types, cognitive and moral (c.f. Johnson et al 2006). After talking with different practitioners, I realized that many of them relied upon another type of legitimating claims. Suchman (1995) terms this third type pragmatic. Pragmatic legitimating claims emphasize the particular course of action's potential benefit to the evaluator.

For example, most acupuncturists seem to agree than licensing is favorable, although it potentially compromises the autonomy of the profession, since it helps keep standards high and consistent, an important characteristic in a new and aspiring healing profession. High standards benefit the profession, and as the profession increases in stature, the stature of the individual practitioners will rise as well.

Challenges to the pragmatic legitimacy of acupuncture emerged on the part of physicians, however, who expressed concern over the cost of treatments for patients. LAcs, not surprisingly, were more likely to discuss the effectiveness of acupuncture than to mention the cost of acupuncture, although a few did express concern for patients' financial burdens. When questioned about why someone should seek treatment with an acupuncturist, a common answer was, "Because acupuncture works." As they explained, patients did not necessarily need or want to know *how* it worked, but only *that* it would work. This was also a concern for practitioners who made referrals to acupuncturists. However, if the money was well spent, then it would be a pragmatically legitimate treatment option.

Several medical acupuncturists disclosed that they would refer patients to LAcs if they thought it might help or be more efficient. Hua explained how she decides on an acupuncturist as a referral:

> I usually have to know them beforehand. Know that they are good acupuncturists. I don't really mind whatever technique that they're doing, as long as they're effective and they, you know, are for patients, they have good results, and they know their anatomy well, then I really don't care what technique they use or if they -- even if they use a different approach than I do. (Hua, MDA)

In this case, the practitioner is neither translating the medicine into a more easily digested form through cognitive legitimating claims nor making a claim that one form or medicine is better or more appropriate. Here, his concern is primarily with how effective the treatment will be, based on predictors he assigns: patient orientation, knowledge of anatomy, and previous successes.

Sarah, a physician, explained that she finds herself unable to explain the mechanisms behind Chinese medicine to patients whom she nevertheless thinks would benefit from it. In these cases, she tells patients of positive experiences she has had personally with acupuncture, and of studies she has read that show it to be effective.

> [Acupuncture is more difficult to explain than chiropractic] because it's not something you can quantify … and I think it's more alternative than chiropractor. It's a little bit less easy to explain the mechanism, because we still don't know the mechanism of why it works. So it will be more like, "I found it to be helpful," or "Studies have shown it to be helpful in such and such disease." … I find that if I bring some science in it, there are some people who might be more skeptical initially, but then are willing to try it.

Note in the quote above that she attempts to translate the medicine using cognitive legitimating claims, but when that fails, she uses pragmatic claims to offer additional support for her suggestion.

Sarah went on to explain that she also bases her decisions on the financial impact of pursing treatment that is not often covered by insurance, and she expects patients to do the same:

> Usually also it's easier with people who have good insurance that covers it, but [it can be hard] to pay for acupuncture $150 a visit; it's a big strain for them to

> pay, when they don't know if it's going to work or why it's working. So, I try to encourage, but certainly not force it, because sometimes it doesn't work for people. You know, I've sent some people to acupuncture, and they say it didn't help. So, since it's an unknown, I just refer differently. (Sarah, MD)

Many physicians spoke of the expense of acupuncture, indicating that they did not want to encourage patients to spend money they might not have. Some of the infertility specialists suggested that their patients might be willing to try any type of treatment out of desperation. Not knowing how to judge an acupuncturist due to a lack of familiarity with the mechanisms behind the medicine or the certification of practitioners, physicians often drew from their main source of evidence: patient report.

Patient report is important even when the practitioner understands how acupuncture works. The medical acupuncturist quoted above explained that he, too, relies heavily on patient report when deciding whether to refer a patient to a licensed acupuncturist, and if so, to whom. This is also extremely important for licensed acupuncturists who are trying to get referrals:

> … I usually only refer my patients to people who I know, and I saw their work, and I have good feedback from the patients, you know. Like, if I refer, let's say, ten patients going to an acupuncturist, and 6 or 7 of them coming back and telling me that that was good, then I will continue to refer patients, but if I don't hear from people saying good things about the acupuncturist, I may stop doing that.
>
> Interviewer: Do you ever get notes from them on the patient's progress?
>
> Rarely—I would like actually them to send me notes and everything—but not quite often. But I do really get in touch with patients who refer out. So their feedback is very valuable to me. (Hua, MDA)

Few of the LAcs I spoke with sent notes to the physicians about the diagnosis and treatment plans they had worked out with the patient. None of the physicians I interviewed received notes from acupuncturists to whom they referred their patients. This was the case much to their chagrin; they were almost all very interested in finding

out more about acupuncture. Because MDs did not know very much about the mechanisms by which acupuncture works, and because scholarly research seemed inconclusive or contradictory at times, and because many MDs expressed concern about giving patients false hopes or exacerbating financial hardship, they relied heavily on input from patients when decided whether or to whom to refer someone who asked them about acupuncture. This input was used to inform the pragmatic legitimating claims they made about acupuncture when explaining treatment options to a patient.

DISCUSSION

On a basic level, cognitive legitimating claims involve sense making, or creating or selecting one theory or explanation over another. When making sense of something, a person comes up with a story about how something works based on his or her understanding of how the broader world works. As new healthcare paradigms move toward the mainstream, explanations for acupuncture and other complementary and alternative modalities still draw on theories and explanations grounded in understandings of health and the body developed and nurtured in a healthcare environment dominated by conventional Western approaches. Because of this, I expected that cognitive legitimating claims would draw from conventional biomedical theories to explain integrative or alternative medicine, which they did.

Findings on cognitive legitimating claims indicate that cognitive legitimation has been occurring at an institutional level, since conventional explanations are frequently part of the acupuncturists' education. In this case, educational institutions prepare acupuncturists to compete in a field in which challenges are expected from the dominant actors.

Educational institutions and other experiences of acupuncturists do lead to differences in moral legitimating claims, though. Although acupuncturists often made a point of emphasizing that conventional medicine is very beneficial in situations of acute need or surgical intervention, their explanations of Chinese Medicine frequently suggested a "care" rather than "cure" approach. Acupuncturists were quick to point out the benefits made possible by the more all-encompassing treatment plans they offered.

Problems with conventional medicine were mostly attributed to insurance companies, which, according to many practitioners, have far too much control over the practice of medicine. Physicians frequently mentioned that they would like to be able to spend more time with each patient, but that their hands were tied due largely to decreasing reimbursement rates for their services.[19] Many simply could not afford to spend as much time as they wanted with each patient. Acupuncturists, on the other hand, frequently mentioned the large amount of time that they had the luxury of spending with the patient. Several acupuncturists explained that they were not going to be taking insurance, even from those companies that provided it, because they wanted to maintain the ability (financially) to spend sufficient time with their patients.

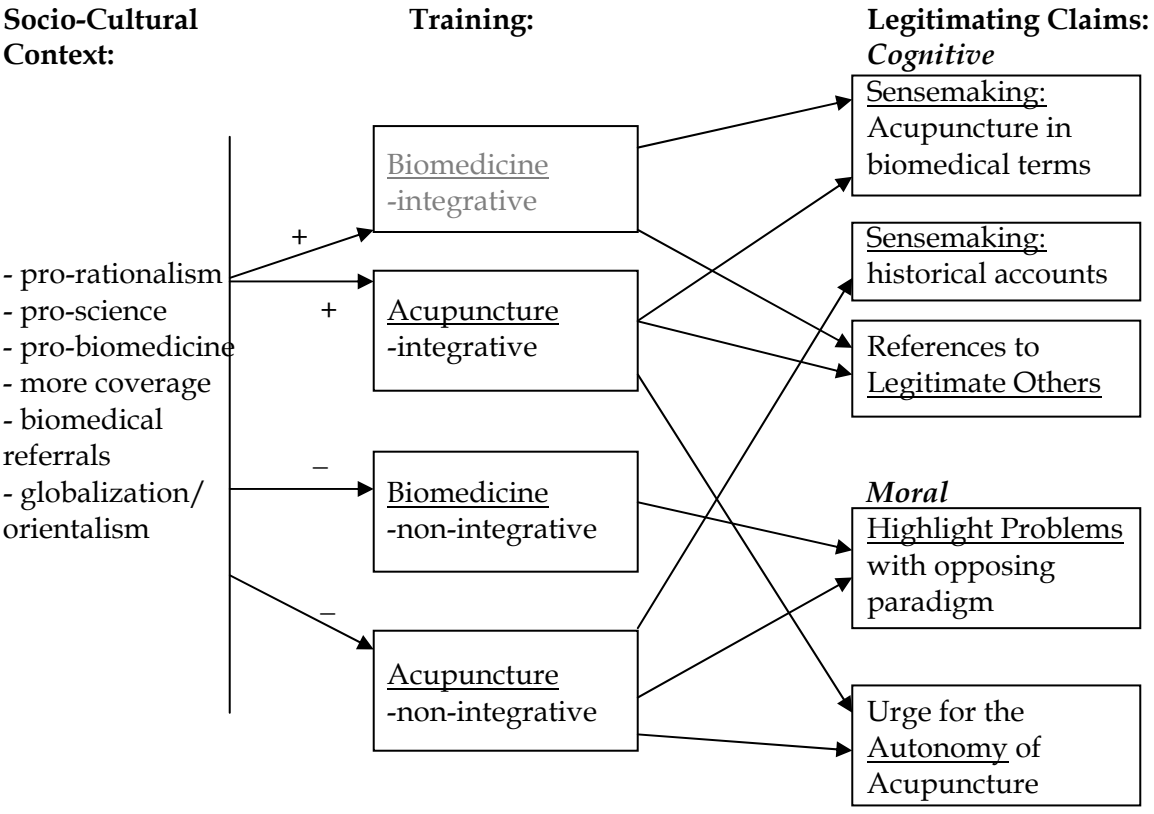
As I illustrated in Diagram Eight (below), I expected the type of training received by a practitioner to impact the types of legitimating claims used. I was surprised to find that almost all acupuncturists, integrative and non-integrative, used biomedical explanations to cognitively legitimate acupuncture. Understandably, the non-integrative

[19] One physician explained that he would not take insurance *in order to be able to afford* treating lower-income patients, since insurance regulations would require him to charge the patient at least the amount the insurance companies are paying for each service. In other words, if he wanted to waive fees or lower rates for someone who legitimately could not afford treatment, he would have to charge the insurance companies the same amount. This is why many of the physicians I spoke with were unhappy with Medicare also, since they set prices low, physicians are required to comply, and insurance companies drive down their reimbursement rates even lower.

acupuncturists were less inclined to do so, however. Fewer practitioners than I expected used historical accounts to make sense of acupuncture.

Practitioners commonly mentioned "legitimate others" – almost all kept up with current conventional scientific research on acupuncture and Chinese Medicine. Fewer practitioners than I expected chose to highlight problems with other healthcare modalities; they all attributed most problems to insurance companies (although more acupuncturists than physicians also held pharmaceutical companies to blame). Instead of blaming other modalities, practitioners were inclined to emphasize all the good that they (and their modality) could do for patients.

Diagram 8: Legitimating Claims.*



**Regarding the proposed influence of training on moral and cognitive legitimating claims: unmarked arrows indicate a positive influence; missing arrows indicate a negative influence.*

Almost all practitioners supported the autonomy of acupuncture, with a caveat: herbs were much more problematic than I expected, even for acupuncturists, many of whom seemed to doubt that all of those practitioners who use them are fully qualified, or are sufficiently keeping up with the conventional medicines their patients are taking.

As I expected, legitimating claims sometimes help maintain boundaries between the different types of practices, most commonly with moral legitimating claims like this one. They are a common tool that practitioners use to justify their healing modality or attempt to elevate its status. In addition to moral and cognitive legitimating claims, pragmatic legitimating claims prove important when cognitive claims and moral claims are insufficient for making a decision about acupuncture. These may make the difference between whether or not a physician recommends acupuncture treatment to a patient or refers a patient to an acupuncturist. For this reason, it is crucial that sufficient claims exist to warrant a referral, if the mainstreaming of acupuncture is to continue.

Chapter Seven: Conclusion
Redefining "Medicine"

In this study, I have shown that boundary work and legitimating claims are prominent in the way that healthcare practitioners structure and think about their work. Practitioners use social boundary work by working in separate spaces and on different problems, which makes collaboration much less likely. They use symbolic boundary work to justify these divisions; in doing so, they position one type of healing practice as ideologically or culturally distinct from another type. Without collaboration, these physical and ideological distinctions may become oppositional, and practitioners may become competitive. Practitioners use legitimating claims – cognitive, moral, and pragmatic – to justify the choice of healing practice they have chosen and assure patients that they, too, have made the best choice.

At the outset of this project, arguments about collective identity drawn from the social movements literature led me to expect that acupuncturists, medical acupuncturists, and physicians would use boundary work to maintain distinctions between their own and other forms of healing (Taylor and Whittier 1995, Polletta and Jasper 2001, Hsu 2001, Rosigno and Danaher 2001, Goldner 2001). Specifically, I expected to find evidence of two types of boundaries: social and symbolic (Lamont and Molnár 2002). By keeping themselves and their practices physically distinct from one another, practitioners reinforce social boundaries. When social boundaries are more permeable, practitioners use symbolic boundaries to maintain distinctions.

The literature on organizations makes it clear that acupuncturists must professionalize to secure and maintain a legitimate place in the healthcare field. As part of the process of professionalization, ways of socializing are established that influence

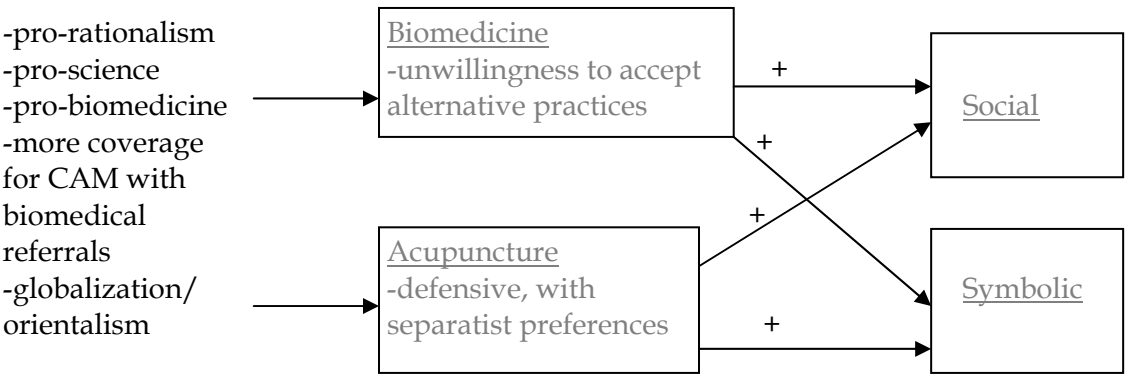
professionals to understand the world in a way that complies with their profession's perspective (Abbott 1988). Research on organizational culture led me to expect that acupuncturists, relatively new professionals in the medical field in the United States, would present their profession as similar to conventional medicine, the dominant profession, in order to gain legitimacy. At the same time, they would portray their profession as distinct from it in order to convey a unique identity, opening up a niche for itself (see Strandgaard Pederson and Dobbin 2006). They would need to show compatibility with the dominant profession, yet they would also need to show that there are contributions they can make that cannot be made by the dominant professionals.

Data from my interviews with physicians and acupuncturists in the summer of 2007 and spring of 2008 supported my expectations that practitioners would use social and symbolic boundaries to distinguish their practice, and legitimating claims to justify and defend it. More specifically, that the groups would use different types of boundary work, and make legitimating claims, both cognitive and moral, to potentially boost their legitimacy in the healthcare field. In addition, I found that pragmatic legitimating claims were also important in this regard. I will briefly review my findings in the areas of boundary work and legitimating claims below.

Boundaries

Hypotheses regarding boundary work are represented schematically in Diagrams Three and Four below. Strong social boundaries reflect the attempt to maintain professional dominance (by non-integrative physicians) or claim a particular niche market or healthcare type (by non-integrative acupuncturists). Integration of the

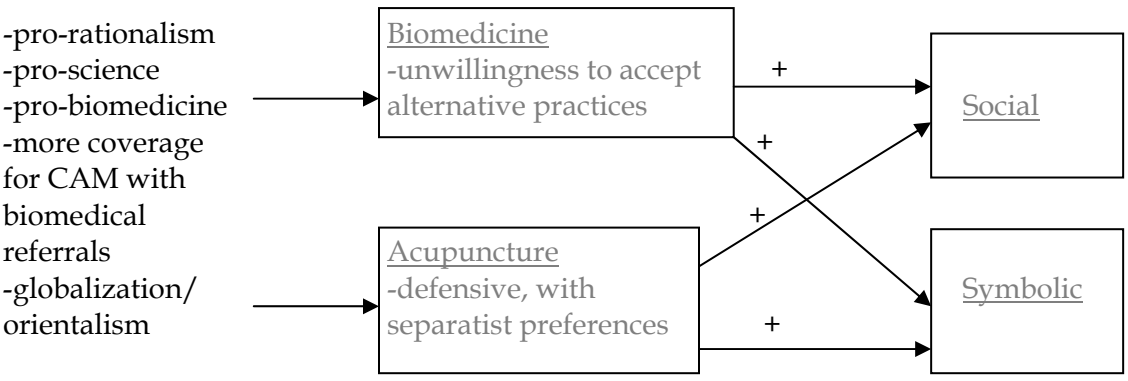
Diagram 9: Boundary Work/Integrative Practitioners.



two types of healthcare practitioners (acupuncture and conventional medicine) indicates a weakening of social boundaries between the two types of practice.

My interviews confirmed my expectations regarding social and symbolic boundaries. Medical acupuncturists' social boundaries tended to be relatively weak, which is to be expected since they are both physicians and acupuncturists at the same time. Integrative practitioners who worked professionally with practitioners from healthcare modalities different from their own were often located more closely together spatially and geographically. They spoke with each other more frequently and cooperated more openly. Also, although evidence shows that general categories of acupuncture tasks and conventional medicine tasks were differentiated,

Diagram 10: Boundary Work/Non-Integrative Practitioners.



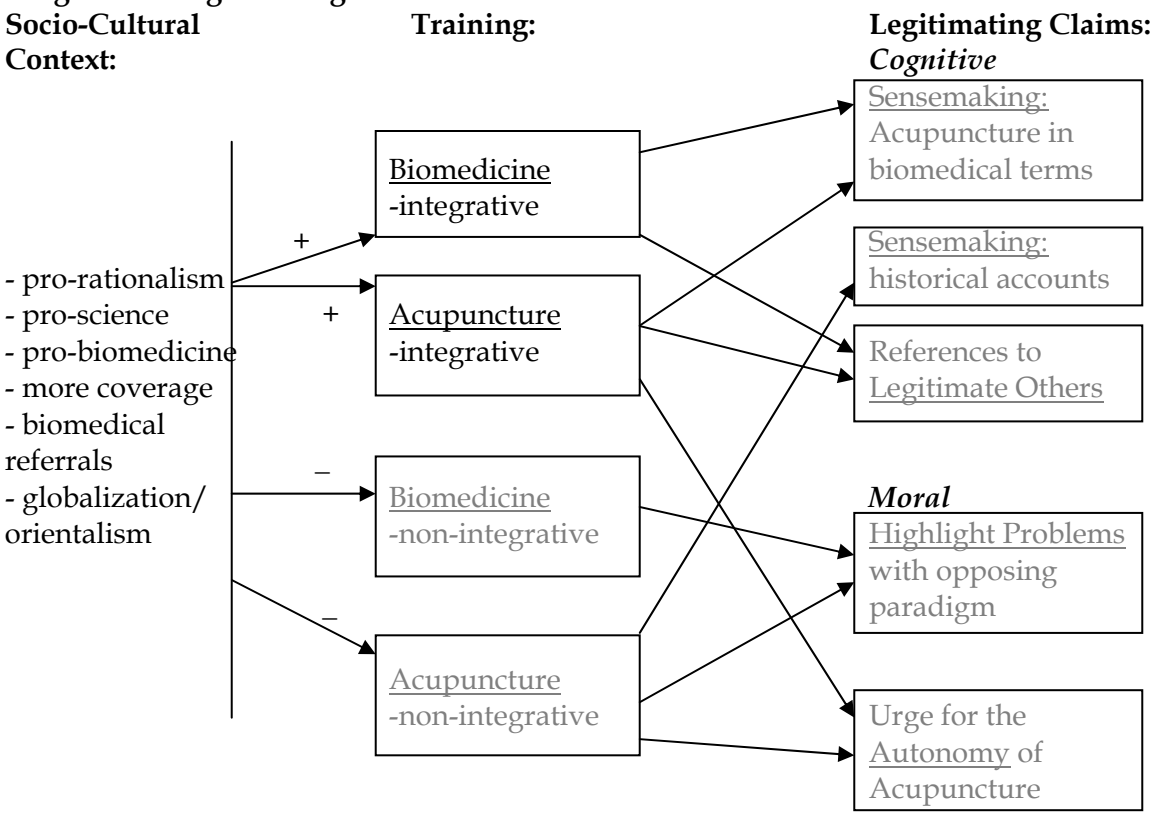
practitioners often failed to articulate the specific tasks, which further indicates the weakening of social boundaries.

My interview data also indicated that, in line with my expectations, non-integrative physicians characterized acupuncture as completely different in nature and approach from conventional medicine. Integrative physicians maintained strong symbolic boundaries as well; many medical acupuncturists, for example, marked their acupuncture treatment rooms with acupuncture-specific anatomical diagrams and included unconventional elements in their treatment rooms, such as playing music and burning candles or incense. However, in many ways symbolic boundaries were still weaker for this group than for non-integrative acupuncturists, whose practices were usually marked not only by symbols of acupuncture, but also by symbols of Chinese or Japanese culture and the use of Chinese diagnostic language. Such symbols clearly set apart their healing processes from conventional modalities.

Legitimating Claims

Hypotheses are represented schematically in Diagram Four below. As I expected when hypothesizing about cognitive legitimating claims, most of the acupuncturists offered explanations of their practice in conventional medical terms. In fact, even acupuncturists with weak ties to physicians and other conventional medical institutions were familiar with conventional medical explanations of acupuncture, although they did not rely on these explanations to assert the value or effectiveness of Chinese Medicine. Although I was somewhat surprised by the familiarity of Licensed Acupuncturists with conventional explanations, I was less surprised by their assertions that these explanations are insufficient for explaining the benefits of acupuncture or Chinese

Diagram 11: Legitimating Claims.*



**Regarding the proposed influence of training on moral and cognitive legitimating claims: unmarked arrows indicate a positive influence; missing arrows indicate a negative influence.*

medicine. I expected that non-integrative acupuncturists, more so than integrative acupuncturists, would emphasize acupuncture's historical background or longevity, claiming that its value is demonstrated by its long period of development and practice. Many emphasized the historical longevity of acupuncture, or presented the philosophy behind Chinese medicine as sufficient for making sense of this healing modality. Acupuncturists relied less on historical longevity as a justification than I expected.

Practitioners also invoke legitimate knowledge sources for cognitive legitimation. As I expected, almost all acupuncturists mentioned studies of acupuncture in conventional medical journals. This almost automatic mention of scientific research journals and schools is likely due to the influence of their educational training and

subsequent experience in the medical field, dominated as it is by conventional medical practitioners and institutions. As I expected, this tendency was even more pronounced among medical acupuncturists.

I expected practitioners to use claims about a practice's corruption or danger to refute a practice's moral legitimacy. I found that although some did, most acupuncturists did not specifically mention the dehumanizing aspects biomedicine, but they often emphasized their own willingness and ability to spend large amounts of time with patients, with the implication that they were able to treat the whole patient and see the larger picture of the patients' health better than physicians. However, acupuncturists often made a point of emphasizing that conventional medicine is beneficial in situations of acute need or when surgical intervention is required. Problems with conventional medicine were mostly attributed to insurance companies, which, according to many practitioners, have far too much control over the practice of medicine.

I was surprised by the number of comments practitioners made about the dangers of herbs, especially when acupuncturists made these comments. Fears of these dangers were exacerbated by the lack of available certification in herbs in Georgia. Without a standardized certification process, many physicians (and some acupuncturists) feared patients might put themselves under the care of inadequately trained practitioners, jeopardizing both their own health and the effectiveness of physicians' treatment. These arguments reflected doubts about the moral legitimacy of Chinese Medicine. They are surprising because of the history of challenges to the moral authority of conventional medicine made because of pharmaceutical errors or side effects (e.g. Thalidomide birth defects). At the same time, it is reasonable to presume that MDs would hold other medicines up to the standards to which they hold conventional

medicine itself, and also that this would be an almost visceral response, given their thorough knowledge of the potential dangers of their own medicine.

As I expected, all acupuncturists argued in favor of their own autonomy, integrative or not. That is, they argued that acupuncturists are capable of operating without the supervision of a conventional physician. Some also pointed out that medical acupuncturists who completed only three hundred hours of training were subject to looser regulation that acupuncturists who had been trained for four years, implying that if any practitioners should need supervision, it would be those who have been trained in acupuncture the least, not the most. However, acupuncturists supported the licensing process in general, seeing it as a necessary component for building a legitimate healthcare profession.

Contrary to my expectations, physicians were also inclined to allow acupuncturists the freedom to practice as they see fit, admitting that since they do not understand acupuncture, they have to trust that acupuncturists know what they are doing, attributing moral legitimacy to the medicine's practitioners, although it seemed they would rather understand more about the treatment their patients are seeking. On the other hand, physicians did not favor giving acupuncturists complete freedom; they felt acupuncture was suitable only for a certain range of conditions, while for others only biomedicine was appropriate.

A third type of legitimating claim, pragmatic, also proved important to practitioners of both modalities: conventional MDs used them to help decide whether to refer patients, and to help explain it to interested patients, to the best of their abilities. I did not expect this type of claims from the outset, but it is easily understood,

considering the ways in which practitioners compete for patients in the current "medical marketplace," in a sense.

Challenges to acupuncture's pragmatic legitimacy emerged on the part of physicians, who expressed concern over the cost of treatments for patients who usually pay out of pocket for CAM treatments, since they are usually not covered by health insurance. However, physicians are able to use pragmatic claims when patients inquired about acupuncture; they were able to talk about the successful experiences of other patients, which may encourage the questioners to report back as well, keeping the lines of communication open between physicians and patients.

Although a few acupuncturists expressed concern for patients' financial situation, they were more likely to discuss the effectiveness of acupuncture than to mention its cost. They often regretted that treatment was expensive but emphasized the good that it could do, along with the thoroughness and simplicity of acupuncture certain conditions, compared to biomedical treatments. Acupuncturists are able to balance the cost with claims that despite the financial burden, acupuncture will help get to the root of the problem, rather than treating it systematically. Thus, even the financial burden is misleading, since it will potentially prevent future discomfort and expenditures.

Physicians also indicated that they use pragmatic legitimating claims when recommending acupuncture to patients, since they are usually unable to explain how acupuncture works. However, this is always done with the recognition that patients may not be able to afford acupuncture. This may help explain why none of the physicians mentioned strongly recommending it to their patients, although many of them were supportive of it. Medical acupuncturists are able to use multiple modalities in

tandem or switch if one modality is not effectively treating the patient's complaint. Additionally, as MDs, insurance companies are more likely to cover their services.

LIMITATIONS AND FUTURE DIRECTIONS

This study was subject to a few limitations. First, I intended to have a larger sample. Unfortunately, securing such a sample was not possible for this project. I hope to build on this project by including a larger number of practitioners. Survey data are available which indicate the openness of healthcare practitioners to CAM. Inclusion of a (broad) quantitative component would strengthen the (deep) qualitative data I have collected.

Second, as a result of this (and as a result of the data gathering process), I included medical acupuncturists as a substitute for integrative acupuncturists and physicians. Theoretically, it seems that these medical acupuncturists could be substituted for integrative physicians, but integrative acupuncturists are different. Calliope (LAc), as an acupuncturist who returned to school to become a registered nurse, is an example of someone I would prefer to include in my sample of integrative acupuncturists.

This study is also limited to describing individual experiences of a process that is occurring on an institutional level as well. While individuals are the enactors of such change, and are therefore intimately involved in this process, an examination of institutional level changes is crucial for understanding the current situation for integrative medicine. In order to do so, I would need to examine changes occurring within national trade associations by a content analysis of their trade journals over time. Another important location this is occurring, as I have noted previously, is in medical

schools. Therefore, it would be enlightening to include an examination of medical curricula and the ways in and extent to which these are changing.

Focusing on individual experiences is also problematic because I only focus on individuals on one side of the medical marketplace. How are the beliefs and behaviors of consumers (patients) influencing the increasing permeability of social boundaries? Survey data are available that include this type of information, and in the same way I have mentioned above, quantitative and qualitative study of patients perceptions and use of CAM would be very enlightening.

In the future, I also hope to use the interview data to outline visions of the future of healthcare as envisioned by these practitioners. All of the subjects provided fascinating predictions or made strong pronouncements about it.

BOUNDING AND LEGITIMATING MEDICINE

As this study has shown, acupuncturists and physicians, including medical acupuncturists, use boundary work and legitimating claims in their daily practices. Symbolic boundaries are important to practitioners, most notably among non-integrative practitioners. They serve as points of demarcation between practices, which allow practitioners in each field to defend the potential of their medicines (and only their medicines). Despite the symbolic boundaries, however, when social boundaries are weakened, integration of the two can occur. Use and research of both modalities becomes possible, which increases awareness of the previously marginalized modality among potential patients and among those who may refer patients to practitioners of the modality.

In the healthcare field, patients are challenging or questioning the dominance of conventional medicine as other options become more available. Legitimating claims are often the means by which historically marginalized healthcare practitioners, such as acupuncturists, position themselves as acceptable and useful healthcare options.

Cognitive legitimating claims help a patient, or a practitioner from another modality, see the treatment option as a viable one; the previously marginalized modality enters the consciousness in a way that makes sense, thus allowing someone to see it as a realistic healthcare option. Moral legitimating claims make an option seem not only viable, but one that will be good for them. Additionally, the CAM practitioner, in this case acupuncturist, can provide care that conventional medicine, for all its strengths, cannot. Pragmatic legitimating claims are useful because they can convince potential patients of the benefit of CAM modalities to them, and convince physicians that using the modality will help their own treatment regimen work more effectively. All three forms of legitimating claims proved important to participants in my study.

Boundary work and legitimating claims facilitate the move from marginal to mainstream, as Ruggie (2004) describes it. They also serve those in mainstream (conventional) medicine, by broadening treatment resources, potentially creating more success for the treatment of their patients.

More broadly, however, boundary work and legitimating claims serve the purpose of redefining "good medicine." Perhaps scientific studies are inconclusive about acupuncture, but practitioners use cognitive, moral, and pragmatic legitimating claims to allow marginal and mainstream medical actors to see it as compatible with the dominant medical paradigm. Perhaps many of the benefits of acupuncture can be explained scientifically, but the symbolic boundary work performed by practitioners

allows marginal and mainstream actors to see it as different enough to warrant the existence of separate healing professions, rather than as something that can or should be co-opted by conventional medicine.

Despite these differences, the breaking down of social boundaries due to continued scientific research, integration into medical curricula, and increased use of CAM by the public (which often results in *de facto* integrative medicine) makes it likely that as time passes, the changes to the medical field will be enduring, and integration will be a more common practice. Physicians will continue pursuing training in medical acupuncture as its benefits become more widely accepted, but symbolic boundaries maintained by acupuncturists will make it highly unlikely that medical acupuncture will ever replace the distinct acupuncture profession. Instead, the broadening definition of "good medicine" will make distinct CAM modalities more acceptable and available to patients and physicians alike.

Epilogue: Machine or Garden?
Enchantment and Integrative Medicine

The healthcare field is expanding; changes in medical organizations, medical school curricula, patient-consumer demand, and the promise and availability of alternative paths to healing are only the most recent in a long history of shifts in medical knowledge and authority.

Early Western medical approaches were based on the Hippocratic ideal of *vis medicatrix naturae*. Specifically, the body was accorded the (limited) capacity to heal itself, and the physician's task was to facilitate this process. This parallels the Weberian concept of enchantment: the body and nature were not completely knowable, and the ability to heal was not something doctors claimed but something the body could do. The body in this way is powerful, and the physician and patient work together for healing, rather than the physician providing healing to the patient. In this way, the relationship of the physician to the body resembled the relationship of the gardener to a garden.

As time passed, medical knowledge expanded, and advances in physiology and surgery made it possible for physicians to actually intervene in the healing process. This *heroic intervention* made it possible for patients to recover from conditions that in the past would have killed them. Thus, physicians came to see themselves (and be seen) as medical heroes. These methods were often dangerous and could do more harm than good, but with continued research and practice, advances were made; over time medicine became safer and standardized. As Western medicine underwent these advances, the body and its care became more and more knowable, and less and less powerful and mysterious: in other words, it was disenchanted. In this sense, the body

became was treated more like a machine, and the physician was expected to fix it if broken, like a mechanic.

By the time Western medicine came to dominate healthcare in the United States, the body was rationalized, knowable, and thoroughly disenchanted. Physicians continued focusing on interventionist care of the body, which led to a focus on acute care, or *cure*, as opposed to preventative, holistic medicine. As time passed, this focus has paid off in the dramatic increase in numbers of conditions treatable with Western medicine. In this way, the mechanical problems visible to the mechanic increased, and the number of such problems the mechanic could fix increased as well. With rapidly advancing interventionist measures, medical marvels such as brain surgery and heart transplants came to be more common and visible, and the public came more and more to see physicians and biomedicine as holding the answers to how the body works and how illness can be cured.

The approach to healthcare outlined above has two logical consequences. First, as many of the participants in this study acknowledged, patients no longer feel required to play an active role in their own health care. In the same way a mechanic might open up a car to fix a broken radiator, patients expect physicians to be able to open them up and fix a broken leg or heart disease. Second, while the ability to treat so many previously disastrous, emergency health problems and the desire to come up with more such "miracle cures" contributed to a focus on acute cures than on chronic care, it also led to more focus on individual interventionist cures than on public health preventative measures.

The above mindsets are problematic, however. Clearly, interventionist measures for a broken leg or arm are more reliable and straightforward that interventionist cures

for a condition such as heart disease. Diseases like heart diseases are some of the biggest threats to the health of the United States population, and can be prevented or kept under control for many people by diet and lifestyle changes. However, during the day, the public is much more likely to see advertisements for pharmaceutical drugs available to treat it or for hospitals that have advanced treatment abilities for it than to see public health announcements encouraging them to turn off the television and go for a walk. Other illnesses, such as fibromyalgia, are not clearly affected by lifestyle changes, but the treatments available through interventionist measures are frequently costly and ineffective.

As the holders of all knowledge of the body, patients have frequently come to view healthcare as something physicians do to or for them. When they are unable to prevent diseases like heart disease or cure diseases like fibromyalgia, patients sometimes seek out alternatives. In this sense, conventional medicine primarily positioned itself as acute *cure*, and patients came to see limitations of Western medicine in the *care* of patients' chronic or ambiguous illnesses.

And in fact, expectations may be rising as interventionist medical miracles increase in frequency, even for treatment of such illnesses. More forms of treatment are available, so patients have access to more medications for previously untreatable illnesses; however, this also creates a larger pool of patients who are potentially dealing with side effects of strong medications. As patients search for care in the form of relief of these conditions, they are finding CAM.

This also reflects a desire on the part of patients to reclaim some of the healing power they had surrendered to physicians. Patients have found that many Eastern medical practices, such as Chinese medicine, portray the body as capable of healing

itself of many of these chronic conditions, given the appropriate facilitation or facilitator. The mechanisms by which this is possible are not always known or understood, but the fact that it works is often sufficient. In this way, the process of healing the body remains "enchanted." The practitioner-patient relationship is moving out of the mechanic's garage and into the garden once again. The drive to rationalize, or disenchant, the body in the first place is something that has been more pressing to Western medicine as it has developed than Eastern medicine, which underwent a much different legitimation process as it developed. While conventional interventionist treatments are available for acute needs, the view of the body as a garden, which must be maintained in order to thrive, has been remembered, and is becoming more common in the West (again).

This return to *vis medicatrix naturae* presents the potential for truly integrative medicine. Both medicines began with an understanding of the body as a unique living thing, which must be maintained; Eastern medicines have held onto these views, and Western medicines have made almost miraculous advances in the ability of physicians to solve acute ('mechanical") problems. The disenchanted body cured by Western medicine is the same enchanted one cared for by Eastern medicine. As conventional medical research continues to highlight mechanisms by which the body is able to achieve the healing facilitated ("nurtured") by Eastern medical practices, this form of medicine may become more rationalized. However, it will never become completely rationalized and standardized since every body, according to these philosophies, is distinct and requires different treatments.

All gardens have different requirements, since every garden has slightly different soil, receives different amounts of water and sunlight, and contains different plants. At the same time, every garden potentially faces certain general problems, such as a pest

infestation, which requires a standardized treatment. In this analogy, it is clear that interventionist cures and ongoing care both are necessary to maintain the health of a garden.

The same can be said for each human body. Like a garden, every body is enchanting in its own way. Each body can benefit tremendously from ongoing individualized care available through CAM, but each body may, in emergencies or in facing life-threatening illnesses, need the standardized life-saving medical intervention made possible through conventional medicine. Therein lie the benefits of integrative medicine.

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APPENDIX 1: From Research Question to Interview Answer in Four Parts

Main Research Question:

To what extent do the (social and symbolic) boundary work undertaken and (cognitive and moral) legitimating claims made by (integrative and non-integrative) medical practitioners vary according to the training (and professional development) they have pursued?

Part 1

Research Question/ Hypotheses	Concepts (*abstract elements of theory*)	Indicators (*operationalizations of concepts*)	Interview Questions
RQ1: ***To what extent does the social boundary work carried out by practitioners vary according to the training they have pursued and types of practice they have chosen?***	**Concept A:** *Social boundary work*	**Indicator A1:** *Task specialization (access to opportunities)*	**Example:** • Are there patients or conditions that you tend to treat more than a different type of practitioner?
		Indicator A2: *Degree of collaboration (access to resources)*	**Example:** • Under what conditions would you work with practitioners of a different healthcare paradigm?
Hypothesis 1: ***I expect that integrative practitioners will have weaker social boundaries than non-integrative practitioners.***		**Indicator A3:** *Geographical separation (access to resources)*	**Example:** • Please describe your work building(s) or location(s).
	Concept B: *Training*	**Indicators B1 and C1:** *Integrative (acupuncture)*	**Record specialization**
		Indicators B2 and C2: *Integrative (MD)*	**Record specialization**
	Concept C: *Practice*	**Indicators B3 and C3:** *Non-integrative (acupuncture)*	**Record specialization**
		Indicators B4 and C4: *Non-integrative (MD)*	**Record specialization**

Part 2:

Research Question/ Hypotheses	**Concepts** ***(abstract elements of theory)***	**Indicators** ***(operationalizations of concepts)***	**Interview Questions**
RQ2: ***To what extent does the symbolic boundary work carried out by practitioners vary according to the training they have pursued and types of practice they have chosen?***	**Concept A:** *Symbolic boundary work*	**Indicator A1:** *Characterizations/ explanations of different practices as similar (minimal ideological distinction)*	**Example:** • What words would you use to describe (other practices)? • What are some similarities between your approach and (other approaches) to health?
Hypothesis 2a: ***Integrative MDs will draw stronger symbolic boundaries than integrative acupuncturists.***		**Indicator A2:** *Characterizations/ explanations of different practices as distinct and/or incompatible (clear ideological distinction)*	**Example:** • What words would you use to describe (other practices)? • What are some differences between your approach and (other approaches) to health? • What sets your approach apart from others? • Are there certain conditions or treatments that you are more suited to treat than other practitioners?
Hypothesis 2b: ***Integrative acupuncturists will have weaker symbolic boundaries than integrative physicians.***			
Hypothesis 3: ***Non-integrative acupuncturists will draw stronger symbolic boundaries between acupuncture and biomedicine than integrative acupuncturists.***	**Concept B:** *Training*	**Indicators B1 and C1:** *Integrative (acupuncture)*	**Record specialization**
		Indicators B2 and C2: *Integrative (MD)*	**Record specialization**
	Concept C: *Practice*	**Indicators B3 and C3:** *Non-integrative (acupuncture)*	**Record specialization**
		Indicators B4 and B4: *Non-integrative (MD)*	**Record specialization**

Part 3:

Research Question/ Hypotheses	**Concepts** ***(abstract elements of theory)***	**Indicators** ***(operationalizations of concepts)***	**Interview Questions**
RQ3: ***To what extent do the cognitive legitimating claims made by practitioners vary according to the training they have pursued and types of practice they have chosen?***	**Concept A:** *Cognitive legitimating claims*	**Indicator A1:** *Compatibility with biomedical thinking (sensemaking)*	**Example:** • How would you explain (other practices) to your patients if they asked?
		Indicator A2: *Historical background (sensemaking)*	**Example:** • How would you explain (other practices) to your patients if they asked?
Hypothesis 4a: ***Integrative practitioners will emphasize acupuncture's compatibility with biomedical views of health, healing, and science more than non-integrative practitioners.***		**Indicator A3:** *References to legitimate others*	**Example:** • How would you explain (other practices) to your patients if they asked?
Hypothesis 4b: ***Non-integrative acupuncturists will emphasize historical background more than integrative acupuncturists.***	**Concept B:** *Training*	**Indicators B1 and C1:** *Integrative (acupuncture)*	**Record specialization**
		Indicators B2 and C2: *Integrative (MD)*	**Record specialization**
Hypothesis 5: ***Integrative practitioners will refer to legitimate others more than non-integrative practitioners.***	**Concept C:** *Practice*	**Indicators B3 and C3:** *Non-integrative (acupuncture)*	**Record specialization**
		Indicators B4 and C4: *Non-integrative (MD)*	**Record specialization**

Part 4:

Research Question/ Hypotheses	**Concepts** ***(abstract elements of theory)***	**Indicators** ***(operationalizations of concepts)***	**Interview Questions**
RQ4: ***To what extent do the moral legitimating claims made by practitioners vary according to the training they have pursued and types of practice they have chosen?***	**Concept A:** *Moral legitimating claims*	**Indicator A1:** *Problems with other approaches*	**Example:** • What strengths and weaknesses does your approach have? • What strengths and weaknesses do (<u>other approaches</u>) have?
Hypothesis 6a: ***Non-integrative acupuncturists will highlight problems with the biomedical approach to healing.***		**Indicator A2:** *Autonomy of acupuncture*	**Example:** • What role should physicians play in the treatment of patients with acupuncture?
Hypothesis 6b: ***Non-integrative acupuncturists will highlight specific problems with biomedicine.***			
Hypothesis 7a-b: ***Acupuncturists will argue in favor of the autonomy of acupuncture more than physicians, who will desire biomedical supervision, at least.***	**Concept B:** *Training*	**Indicators B1 and C1:** *Integrative (acupuncture)*	**Record specialization**
		Indicators B2 and C2: *Integrative (MD)*	**Record specialization**
	Concept C: *Practice*	**Indicators B3 and C3:** *Non-integrative (acupuncture)*	**Record specialization**
		Indicators B4 and C4: *Non-integrative (MD)*	**Record specialization**

APPENDIX 2: Interview Guides

Physician Interview Guide

BACKGROUND QUESTIONS

(gender; race and ethnicity; age)
What is your specialty and position/title?
How long have you practiced medicine?

GENERAL WORK HISTORY AND ENVIRONMENT

I am interested in the stories people tell about their work – how they got interested in it, how they learned it, how they came to be the place they are. To start with, I'd like you to please tell me the story of how you got where you are. If you were asked to tell the story of how you got into your field, how would it go?

Please describe the building(s) or location(s) in which you work.
What is a "typical" day?
What do your patients expect from you?
How do you provide the best treatment for your patients?
Has your approach changed since you first entered the field?
How frequently do you interact with other types of healthcare practitioners?
With which types of practitioners do you most frequently interact?
What are these interactions like? (e.g. who takes the lead, how are you treated, how do you approach working with someone else, etc.)
How familiar are you with different complementary and alternative approaches to healthcare?
How and to what extent do you keep up-to-date on the latest developments in medicine, integrative practice, and/or acupuncture?
Are you a member of any professional associations?

BOUNDARY WORK

***Social boundaries**: a) task differentiation, b) cooperation, c) spatial separation*

How much contact do you have with other physicians? [c]
Acupuncturists?
(Other) Integrative practitioners?
Are there certain conditions or patients that acupuncturists tend to treat more than other types of practitioners? [c]
Are there certain conditions or patients that physicians tend to treat more than other types of practitioners? [a]
Are there patients or conditions that conventional medicine is more suited to treat than a different type of healthcare provider? Acupuncture? [moral legitimation; b]
Are there conditions for which conventional medicine or acupuncture is not helpful, generally? [moral legitimation [b]
Under what conditions would you work with practitioners of a different healthcare paradigm? Specifically, acupuncturists? Massage therapists, herbalists? Chiropractors? Homeopaths? How likely? One more than another? [b]
Are there some types of practitioners you would not work with under any circumstances? [b]
To what extent do patients' preferences influence your willingness to work with other practitioners? [b]

***Symbolic boundaries**: distinctiveness of paradigms*

What are some key differences characterizing different approaches to healthcare?
What distinguishes your approach from others? (acup vs. CAM vs. biom)
What distinguishes other approaches from one another?

What words would you use to describe the following concepts?
conventional medicine?
integrative medicine?
complementary and alternative medicine?
acupuncture?

LEGITIMATION

Cognitive legitimation*: a) efficacy and safety, b) sensemaking*

What are the biggest challenges in healthcare today? [a]
Are there particular challenges facing certain practitioners or practices more so than others?
Conventional medicine?
CAM?
Acupuncture?
Integrative medicine?
How well do you think they are facing these challenges? [a]

One thing I am interested in is the stories people tell about their professions. Earlier you told me how you got into your particular practice. Now I'd like you to tell me, briefly, the story of your profession (biomedicine).

[PROMPT: When did it begin? How has it gotten to the state it is in now?] [b]
To the best of your knowledge, how does this story differ from the story of acupuncture? [b]
In a general sense, how would you explain the successes of conventional medicine? [b]
Integrative medicine?
Acupuncture?
Other alternative approaches?

Moral legitimation*: a) autonomy, b) problems with other approaches*

How does acupuncture compare to other CAMs in general? [b]
What are the benefits of integrative medicine, compared to other healthcare approaches? [b]
What strengths and weaknesses does your approach have? [b]
What strengths and weaknesses do other approaches have? [b]
What role should regulatory agencies play in the practice of medicine? [a]
Integrative medicine?
CAM?
Acupuncture?
What role should physicians play, if any, in the treatment of patients with acupuncture? [a]

Acupuncturist Interview Guide

BACKGROUND QUESTIONS

(gender; race and ethnicity; age)
What is your specialty and position/title?
How long have you practiced medicine?

GENERAL WORK HISTORY AND ENVIRONMENT

I am interested in the stories people tell about their work – how they got interested in it, how they learned it, how they came to be the place they are. To start with, I'd like you to please tell me the story of how you got where you are. If you were asked to tell the story of how you got into your field, how would it go?

Please describe the building(s) or location(s) in which you work.
What is a "typical" day?
What do your patients expect from you?
How do you provide the best treatments for your patients?
Has your approach changed since you first entered the field?
How frequently do you interact with other types of healthcare practitioners?
With which types of practitioners do you most frequently interact?
What are these interactions like? (e.g. who takes the lead, how are you treated, how do you approach working with someone else, etc.)
How familiar are you with different complementary and alternative approaches to healthcare?
How and to what extent do you keep up-to-date on the latest developments in acupuncture, integrative medicine, and/or medicine? medicine,
Are you a member of any professional associations?

BOUNDARY WORK

Social boundaries*: a) task differentiation, b) cooperation, c) spatial separation*

How much contact do you have with other acupuncturists? [c]
Physicians?
(Other) Integrative practitioners?
Are there certain conditions or patients that acupuncturists tend to treat more than other types of practitioners? [c]
Are there certain conditions or patients that physicians tend to treat more than other types of practitioners? [a]
Are there patients or conditions that acupuncture is more suited to treat than a different Type of healthcare provider? Conventional medicine? [moral legitimation; b]
Are there conditions for which acupuncture or conventional medicine is not helpful, generally? [moral legitimation b]
Under what conditions would you work with practitioners of a different healthcare paradigm? Specifically, massage therapists, herbalists? Physicians? Chiropractors? Homeopaths? How likely? One more than another? [b]
Are there some types of practitioners you would not work with under any circumstances? [b]
To what extent do patients' preferences influence your willingness to work with other practitioners? [b]

Symbolic boundaries*: distinctiveness of paradigms*

What are some key differences characterizing different approaches to healthcare?
What distinguishes your approach from others? (acup vs. CAM vs. biom)
What distinguishes other approaches from one another?

What words would you use to describe the following concepts?
- conventional medicine?
- integrative medicine?
- complementary and alternative medicine?
- acupuncture?

LEGITIMATION

***Cognitive legitimation**: a) efficacy and safety, b) sensemaking*

What are the biggest challenges in healthcare today? [a]

Are there particular challenges facing certain practitioners or practices more so than others?
- Acupuncture?
- CAM?
- Conventional medicine?
- Integrative medicine?

How well do you think they are facing these challenges? [a]

One thing I am interested in is the stories people tell about their professions. Earlier you told me how you got into your particular practice. Now I'd like you to tell me, briefly, the story of your profession (acupuncture).

[PROMPT: When did it begin? How has it gotten to the state it is in now?] [b]

To the best of your knowledge, how does this story differ from the story of conventional medicine? [b]

In a general sense, how would you explain the successes of acupuncture? [b]
- Conventional medicine?
- Integrative medicine?
- Other alternative approaches?

***Moral legitimation**: a) autonomy, b) problems with other approaches*

How does acupuncture compare to other CAMs in general? [b]

What are the benefits of integrative medicine, compared to other healthcare approaches? [b]

What strengths and weaknesses does your approach have? [b]

What strengths and weaknesses do other approaches have? [b]

What role should regulatory agencies play in the practice of medicine? [a]
- Integrative medicine?
- CAM?
- Acupuncture?

What role should physicians play, if any, in the treatment of patients with acupuncture? [a]

APPENDIX 3: Recruitment Letter

Charity Crabtree, ABD
Emory University, Dept of Sociology
Tarbutton Hall, Room 225
1555 Dickey Drive
Atlanta, GA 30322

(Dr.) Jane Doe (L.Ac.)
Address #1
Address #2

Dear _____,

I am a Ph.D. candidate (ABD) at Emory University in the Department of Sociology, and I am writing in the hopes of securing your participation in my doctoral research on conventional medicine, integrative medicine, and acupuncture.

My research questions concern the extent to which your experiences with training and education have influenced the way you see yourself as a health practitioner, and the extent the different groups to which you belong impact this.

I will be interviewing physicians and acupuncturists in the Atlanta area, both those who work together in integrative ways and those who do not. From these interviews I will be able to better understand the ways healthcare practitioners distinguish and draw connections between themselves and other healthcare practitioners.

Potential contributions of this work include an improved understanding of the ways in which health providers work to meet the shifting needs of the individuals they serve, partly through attempts to utilize the most advanced practices and knowledge in their field(s). I hope additionally that this research will highlight mechanisms by which practitioners identify with other practitioners in their field(s) and how this identification affects their practices.

I am writing to solicit your help. I expect these interviews to last approximately one hour at your place of practice or another suitable location that is convenient for you. If you are interested in hearing more about this study, please contact me at cecrabt@emory.edu, or the chair of my dissertation, Dr. John Boli at jboli@emory.edu. Please complete the enclosed form and return in the enclosed pre-addressed envelope for more information or to set up an interview at a time convenient for you.

Thank you for considering participation in this important research project. I look forward to hearing from you.

Sincerely,

Charity Crabtree, ABD (Ph.D. Candidate)
Emory University, Department of Sociology

APPENDIX 4: Request for More Information (Physician): Sociology Study

Title: "Boundary Work and Legitimating Claims Among Physicians and Acupuncturists"
Principal Investigator: Charity Crabtree, Ph.D. Candidate, Department of Sociology, Emory University

Introduction and Purpose
The purpose of this study is to more clearly illustrate the interactions between two types of medical practitioners (acupuncturists and physicians). I seek to understand the views held by these practitioners about their own practice as well. You are being asked to volunteer for this research study because you are a medical practitioner, and as such, your opinions and experiences will be useful in more clearly explaining these interactions and perceptions.

Procedures
Your participation in this study will consist of one interview with the principal investigator, which will be recorded and transcribed. This interview will be conducted at a location and time of your choosing, and it will last approximately one hour. Topics covered in the interview include experiences at work and educational and training experiences you have had, interactions you may or may not have had with healthcare practitioners from practices other than your own, and perceptions about your own and other types of healthcare practice.

Risks and Benefits
There are no known physical, legal, or economic risks to you related to participation in this study. In the unlikely event that you find any of the questions personally uncomfortable, you may terminate the interview or refuse to answer the question. There are also no known benefits to you. Your responses will increase understanding of the healthcare field. I hope that you find the interview pleasant and enjoy telling stories about your profession and approach to healthcare.

Contact Persons
If you have questions about this study, please contact Charity Crabtree by phone at 404-895-9778 or by email at cecrabt@emory.edu. You may also contact my faculty advisors Dr. John Boli (email: jboli@emory.edu) or Dr. Tracy Scott (phone: 404-727-7515, email: tscott@emory.edu).

If you are willing to discuss this research further or would like to set up an interview, please complete the following:

Your name: _____ Phone # or email: _____

Title: _____ Name of Practice: _____

_____ Integrative, with Acupuncturist: I regularly work with other types of practitioners, including acupuncturists.
_____ Integrative, not with Acupuncturist: I regularly work with other types of practitioners, but not acupuncturists.
_____ Non-integrative: I do not regularly work with non-physician healthcare practitioners.

APPENDIX 5: Request for More Information (Acupuncturist): Sociology Study

Title: "Boundary Work and Legitimating Claims Among Physicians and Acupuncturists"
Principal Investigator: Charity Crabtree, Ph.D. Candidate, Department of Sociology, Emory University

Introduction and Purpose
The purpose of this study is to more clearly illustrate the interactions between two types of medical practitioners (acupuncturists and physicians). I seek to understand the views held by these practitioners about their own practice as well. You are being asked to volunteer for this research study because you are a medical practitioner, and as such, your opinions and experiences will be useful in more clearly explaining these interactions and perceptions.

Procedures
Your participation in this study will consist of one interview with the principal investigator, which will be recorded and transcribed. This interview will be conducted at a location and time of your choosing, and it will last approximately one hour. Topics covered in the interview include experiences at work and educational and training experiences you have had, interactions you may or may not have had with healthcare practitioners from practices other than your own, and perceptions about your own and other types of healthcare practice.

Risks and Benefits
There are no known physical, legal, or economic risks to you related to participation in this study. In the unlikely event that you find any of the questions personally uncomfortable, you may terminate the interview or refuse to answer the question. There are also no known benefits to you. Your responses will increase understanding of the healthcare field. I hope that you find the interview pleasant and enjoy telling stories about your profession and approach to healthcare.

Contact Persons
If you have questions about this study, please contact Charity Crabtree by phone at 404-895-9778 or by email at cecrabt@emory.edu. You may also contact my faculty advisors Dr. John Boli (email: jboli@emory.edu) or Dr. Tracy Scott (phone: 404-727-7515, email: tscott@emory.edu).

If you are willing to discuss this research further or would like to set up an interview, please complete the following:

Your name: _____ Phone # or email: _____

Title: _____ Name of Practice: _____

_____ Integrative, with Physicians: I regularly work with other types of practitioners, including physicians.
_____ Integrative, not with Physicians: I regularly work with other types of practitioners, but not physicians.
_____ Non-integrative: I do not regularly work with other types of healthcare practitioners.

APPENDIX 6a: Emory University Consent to be a Research Subject (Written)

Title: "Boundary Work and Legitimating Claims Among Physicians and Acupuncturists"

Principal Investigator: Charity Crabtree, Ph.D. Candidate, Department of Sociology, Emory University

Introduction and Purpose
The purpose of this study is to more clearly illustrate the distinctions between two types of medical practitioners (acupuncturists and physicians) as they define and explain them. To do so, I will be seeking to understand the views held by these practitioners about their own practice as well. You are being asked to volunteer for this research study because you are a medical practitioner, and as such, your opinions and experiences may prove useful in more clearly explaining these distinctions.

Procedures
Your participation in this study will consist of one interview with the principal investigator, which will be recorded and transcribed. This interview will be conducted at a location and time of your choosing, and will last approximately one hour. Topics covered in the interview include experiences at work and educational and training experiences you have had, interactions you may or may not have had with healthcare practitioners from paradigms other than your own, and conceptions about your own and other types of healthcare practice. You will receive a monetary gift of $50 in appreciation for your time.

Voluntary Participation and Withdrawal
Participation in this research study is entirely voluntary. You have the right to refuse to be in this study. If you decide to be in the study and change your mind, you have the right drop out at any time. There is no penalty to you if you withdraw from the study. Also, you may skip any questions that you do not want to answer.

Confidentiality
I will keep your records private to the extent allowed by law. I will use a pseudonym of your choice rather than your name on study records when I can. The records linking your name with the pseudonym will be stored securely, and the only person with access to this information will be myself. The Institutional Review Board will also be able to review study files. Your name and other facts that might point to you will not appear without your permission when I present this study or publish its results. Upon transcription of the interviews, all recordings will be destroyed. You have a right to insist your real name be used instead of the pseudonym.

Risks and Benefits
There are no known physical, legal, or economic risks to you related to participation in this study. In the unlikely event that you find any of the questions personally uncomfortable, you may terminate the interview or refuse to answer the question. There are no known benefits to you, but your responses will increase understanding of the healthcare field. I hope that you find the interview pleasant and enjoy telling stories about your profession and approach to healthcare.

Contact Persons
If you have questions about this study, please contact Charity Crabtree by phone at 404-895-9778 or by email at cecrabt@emory.edu. You may also contact my faculty advisors Dr. John Boli (email: jboli@emory.edu) or Dr. Tracy Scott (phone: 404-727-7515, email: tscott@emory.edu). If you have questions or concerns about your rights as a participant in this research study, you may contact

Dr. Colleen Di Iorio, Chair of the Emory University Institutional Review Board at 404-712-0720 or IRB@emory.edu.

I will give you a copy of this consent form to keep. If you are willing to volunteer for this research, please sign below.

_____	_____	_____
Signature of Study Participant	Date	Time
_____	_____	
Printed Name of Study Participant	Chosen Pseudonym	
_____	_____	_____
Signature of Charity Crabtree Principle Investigator and Interviewer	Date	Time

APPENDIX 6b: Emory University Consent to be a Research Subject

Title: "Boundary Work and Legitimating Claims Among Physicians and Acupuncturists"

Principal Investigator: Charity Crabtree, Ph.D. Candidate, Department of Sociology, Emory University

Introduction and Purpose
The purpose of this study is to more clearly illustrate the distinctions between two types of medical practitioners (acupuncturists and physicians) as they define and explain them. To do so, I will be seeking to understand the views held by these practitioners about their own practice as well. You are being asked to volunteer for this research study because you are a medical practitioner, and as such, your opinions and experiences may prove useful in more clearly explaining these distinctions.

Procedures
Your participation in this study will consist of one interview with the principal investigator, which will be recorded and transcribed. This interview will be conducted at a location and time of your choosing, and will last approximately one hour. Topics covered in the interview include experiences at work and educational and training experiences you have had, interactions you may or may not have had with healthcare practitioners from paradigms other than your own, and conceptions about your own and other types of healthcare practice. You will receive a monetary gift of $50 in appreciation for your time.

Voluntary Participation and Withdrawal
Participation in this research study is entirely voluntary. You have the right to refuse to be in this study. If you decide to be in the study and change your mind, you have the right drop out at any time. There is no penalty to you if you withdraw from the study. Also, you may skip any questions that you do not want to answer.

Confidentiality
I will keep your records private to the extent allowed by law. I will use a pseudonym of your choice rather than your name on study records when I can. The records linking your name with the pseudonym will be stored securely, and the only person with access to this information will be myself. The Institutional Review Board will also be able to review study files. Your name and other facts that might point to you will not appear without your permission when I present this study or publish its results. Upon transcription of the interviews, all recordings will be destroyed. You have a right to insist your real name be used instead of the pseudonym.

Risks and Benefits
There are no known physical, legal, or economic risks to you related to participation in this study. In the unlikely event that you find any of the questions personally uncomfortable, you may terminate the interview or refuse to answer the question. There are no known benefits to you, but your responses will increase understanding of the healthcare field. I hope that you find the interview pleasant and enjoy telling stories about your profession and approach to healthcare.

Contact Persons
If you have questions about this study, please contact Charity Crabtree by phone at 404-895-9778 or by email at cecrabt@emory.edu. You may also contact my faculty advisors Dr. John Boli (email: jboli@emory.edu) or Dr. Tracy Scott (phone: 404-727-7515, email: tscott@emory.edu). If you have questions or concerns about your rights as a participant in this research study, you may contact

Dr. Colleen Di Iorio, Chair of the Emory University Institutional Review Board at 404-712-0720 or IRB@emory.edu.

Would you like me to mail a copy of this consent form to you for your records?

_____ Yes
_____ No

Do you consent to be a part of this study?

_____ Yes
_____ No

Do you have a chosen pseudonym for this project, or would you like me to make one for you?

_____ Yes, _____
_____ No, please make one for me.

_____
Printed Name of Respondent

_____ _____ _____
Signature of Charity Crabtree
Principle Investigator and Interviewer Date Time

Study No.: IRB00003046

Emory University IRB
IRB use only

Document Approved On: 4/4/2008
Project Approval Expires On: **4/3/2009**

APPENDIX 7: Participants

	Gender	Race/Ethnicity	Type of Practice	Setting
Calliope	F	White/Caucasian	LAc and RN w/ LAcs	Comfortable
Jamie	F	African American	LAc Private	Comfortable
Adrian	M	White/Caucasian	LAc Private	"Asian"
Paul	M	White/Caucasian	LAc w/ other types	Luxury
Chen	M	Chinese	LAc w/ other types	Comfortable
Santi	F	Japanese	LAc w/ other types	Luxury
Yuan	M	Chinese	LAc w/ other types	Clinical
Will	M	White/Caucasian	LAc w/ other types	"Asian"
Rick	M	White/Caucasian	LAc w/ other types	Comfortable
Erin	F	White/Caucasian	LAc w/ same types	"Asian"
Lissa	F	White/Caucasian	LAc w/ same types	"Asian"
Emily	F	White/Caucasian	LAc w/ same types	Comfortable
LuAnne	F	White/Caucasian	MDA /Private	n/a
Steven	M	White/Caucasian	MDA w/ other types	Clinical
Rachel	F	White/Caucasian	MDA w/other types	n/a
Mark	M	Unknown	MDA/Unknown	n/a
Hua	F	Chinese	MDA/Unknown	Academic
Mike	M	White/Caucasian	MD Private	Luxury
Aaron	M	White/Caucasian	MD w/ other types	Clinical
Thomas	M	White/Caucasian	MD w/ same types	Clinical
Julie	F	Unknown	MD w/ same types	Academic
Kimberly	F	Unknown	MD w/ same types	Clinical
Isaac	M	White/Caucasian	MD w/ same types	Clinical
Sarah	F	White/Caucasian	MD w/ same types	Academic
Kevin	M	Korean American	MDw/ same types	Academic

Appendix 8: Full Code System

Social Boundaries
- Task Differentiation
- Degree of Cooperation/*Communication
- Degree of Spatial Separation
- Interesting and Unexpected
- *Referrals
- *Patient as mediator
- *Other CAM
- *Practical business aspects
- *Other?

Symbolic Boundaries
- Ideological Distinctions between W & E
- Practical Distinctions between W & E
- *Language/Metaphors
- *Perceptions of Patient Appropriateness
- *Broader concept of "medicine" (lifestyle, etc.)
- *Integrative or no?
- *Other?

Cognitive Legitimating Claims
- Linking w/ Leg Practices (studies, institutions)
- Sense-making (theories, explanations)
- *Popular Culture
- *Other?

Moral Legitimating Claims
- Purity or Corruption/*Danger
- Alternative vs. Complementary
- Need for Supervision
- *One "Better" than the other
- *What is a good practitioner?
- *Other?

***Pragmatic Legitimating Claims**
- *Results Orientation
- *Patients Use Both
- *Pharmaceuticals/Herbs
- *Themselves
- *Industry/Practice
- *Insurance Industry/Practice
- *Other?

Bold type indicates main dependent variables.
Plain type indicates individual codes.
*An asterisk indicates code was added during data collection process.