

The Acupuncture Wars: The Professionalizing of American Acupuncture—A View From Massachusetts

Linda L. Barnes

Since the 1970s acupuncturists in the United States have confronted the dilemma of how to define themselves not only as practitioners in relation to an evolving Americanized version of Chinese medicine but also with respect to definitions of biomedical professional identity, which are currently in flux. The central issue is that of professionalization. This study traces the process of professionalization through the initial reception of the modality; the first steps toward specialized training; and the further steps through professional associations, credentialing, and licensing. This process takes place within the broader social frame of fluctuating definitions of biomedical professionalism. It is within this context that acupuncturists are assessing role definition, status, and compensation. Part of the process also involves the renewed use of the clinical trial and the potential co-opting of acupuncture. The potential for resistance is tied in with alliances with holistic physicians and with acupuncturists' own defense of pluralism.

Key Words: acupuncture, professionalization, Chinese medicine, TCM, medical pluralism, integrative medicine

LINDA L. BARNES is an assistant professor in the Department of Pediatrics at Boston University School of Medicine and in the Department of Social and Behavioral Sciences at Boston University School of Public Health. She is also a visiting lecturer in the Department of Social Medicine at Harvard Medical School. She is cross-trained as a medical anthropologist and a historian of comparative religious studies. Barnes is currently completing the first volume of a social history of European and American perceptions of, and responses to, the Chinese and their healing practices. Address correspondence to Dr. Linda L. Barnes, Maternity Building 405, 91 East Concord St., Boston, MA, 02118. E-mail: lbarnes@fiac.net

INTRODUCTION

Since the 1970s, when Chinese acupuncture re-entered the awareness of the American public,¹ it has encompassed multiple and sometimes conflicting orientations toward practice, practitioner identity, training, credentialing, and social status. Individuals who once saw themselves as countercultural guerrilla figures must now undergo increasingly complex examination and licensing procedures, along with an educational system that, in certain respects, bears a growing resemblance to biomedical training. Some practitioners talk about body, mind and spirit, and the spiritual dimensions of Chinese therapies; others submit proposals for randomized, double-blind, controlled clinical trials to test protocols related to using acupuncture for lower back pain.

This process has unfolded within the context of alternating interest, indifference, and rejection on the part of the dominant biomedical culture (Wolpe 1985). Acupuncturists have confronted the dilemma of how to define themselves not only as practitioners in relation to an emerging Americanized version of Chinese medicine but also in relation to definitions of biomedical professional identity, which are currently in flux. In the midst of this mix, some acupuncturists favor standardizing practice; others adamantly adhere to a pluralistic model. These different approaches to Chinese practices can be read as the different faces of a cultural translation involving multiple contingent forces, all of which are at work within a larger system long characterized by pluralism.

At the center of this translation process is the issue of professionalization, viewed by acupuncturists in the United States as one of the key problems confronting them in the American medical marketplace. As acupuncturists have tried to secure a place for themselves in the medical landscape of the country, they have taken steps that sociologists of professionalization describe as common to those undergoing the process of transforming from being members of an informal group into being members of a recognized professional group (see, for example, Caplow 1996; Carr-Saunders 1996; Larson 1977; Burnham 1998; Becher 2000; Friedson, 1994, 2001; and Leicht and Fennell 2001). At the same time, internal tensions persist. Not all practitioners rest easy with parts of the process or with all of its effects, and this leads to conflicts within what, to a larger public, may appear to be a uniform field. The particulars of the process vary, according to specific local contexts (see Baer et al. 1998). Differences

of opinion regarding the meaning of the particulars have given rise to what, in acupuncture circles, have been called "the acupuncture wars." Drawing on different theories of professionalization, I analyze this process, focusing on Massachusetts, while pointing as well to related dimensions at the national level.ⁱⁱ

MEANINGS OF PROFESSION

As with any concept, "profession" has a political history and there is no absolute definition of the term; rather, it represents a culture-bound folk concept (Last 1990; Friedson 1994) whose specific contours contribute to "understanding and interpreting what is conceived of as a concrete, changing, historical, and national phenomenon" (Friedson 1994:25). In its earliest history, for example, its meaning derived from a religious vow. Protestant reformers extended the term to include not only monastics and priests but also their own clergy and laity. The earlier meaning, however, infused subsequent variations with its dignity. Although, over time, the term leaned increasingly toward the current meaning of "vocation" (Kimball 1992), it has retained an idealized aura of altruism and selfless service.

"Profession" can refer to the conventions by which people recognize a given expertise, including knowledge and related skills. It can include measures taken to: elevate the status of a particular group; regulate the educational process and related training; form professional associations and a code of ethics; secure credentialing and licensing by the state; exercise internal control of the group over its members' practices (including peer review); retain the exclusive right to perform this form of work, along with the power to handicap or exclude competitors (including making it illegal to practice otherwise); and promote measures to advance the economic interests of practitioners (Caplow 1966). Professions can be understood as institutions that "represent identifiable structures of knowledge, expertise, work, and labor markets, with distinctive norms, practices, ideologies, and organizational forms" (Leicht and Fennell 2001:90).

Biomedicine has routinely been elevated as being virtually synonymous with everything paradigmatic and even archetypal about the concept of "profession." Through a curious tautological looping, it has stood as a foundational example not only of what a

profession *is* but also of how a particular group *becomes* a profession. Its example has thereby informed theories of professionalization to the point where biomedicine functions as both prototype and outcome. As such, it has also come to stand as the standard—in ways that frequently ignore historical and cultural variations—against which all other systems of healing are measured.

The study of professions also requires an examination of the social dynamics (i.e., the forces operating on a group as part of a larger system) that prompt groups to take the steps necessary to acquire the attributes listed above. In contexts, for example, where biomedical practice is organized according to criteria assumed to characterize a professional model, any system seeking a place at the table may have little choice but to do its best to emulate and imitate this standard. As Abbott (1988) has argued, one must therefore take an ecological and systemic view of issues of interrelation, competition, and jurisdictional dispute, particularly when the work performed by different groups overlaps.

A definition consisting of lists of attributes, or of steps taken by groups, serves as an intellectual construct providing “ideal types” (Friedson 2001). Yet ultimately the criteria used to characterize the process of professionalization in general and of biomedicine in particular represent, at best, possible touchstones, not all of which are met by other groups striving for—or even achieving—recognition as a profession. For that matter, even when a group calls itself a profession, it is not necessarily recognized as one by others. Such internal differentiation leaves us with “a down-to-earth and commonsense view based on knowledge by acquaintance rather than knowledge by definition” (Becher 2000:7)—a provisional formulation in which “professions are somewhat exclusive groups of individuals applying somewhat abstract knowledge to particular cases” (Abbott 1988:318). The provisional quality of the definition, as we shall see, is at the root of tensions within a field like acupuncture as different parties come into conflict over their take on what characterizes a profession within a broader medical culture.

A TYPOLOGY OF PRACTICES

Practitioners of acupuncture and related modalities in the United States frequently describe themselves as doing “Traditional Chinese Medicine,” a deceptively simple rubric that, in reality, comprises

many subheadings. The term often refers to the version of Chinese medicine known as “TCM” (“Traditional Chinese Medicine”) systematized under the auspices of the government of the People’s Republic of China (PRC) since the 1950s as a national medicine of the Marxist state. To create this system, the PRC government stripped older texts of terms and practices seen as “superstitious,” some of which included more overtly religious dimensions. This censorship represented another step in the gradual “rehabilitation” of traditional medicine in general—and of acupuncture in particular—over the course of the 20th century (Andrews, forthcoming). The sharpest critics of the results point out that never, in its documented history, was Chinese medicine fully dominated by a single school of thought; rather, interacting theories and approaches to practice coexisted and carried forward over time with little overall synthesis. The government’s need to present an ostensibly coherent system came in response to biomedical logic, which often calls for one or the other of two conflicting statements to be authoritative (Unschuld 1987, 1992). Political propaganda notwithstanding, however, the results in China have proved to be anything but unified (Scheid 2002; Barnes, forthcoming b).

During the 1960s, two Chinas seized the imagination of the North American counter-culture. One was the China of esoteric wisdom traditions; the other was the China of the Maoist revolution. The Chinese were, accordingly, the descendants of Laozi and the holders of spiritual secrets leading to enlightenment on the one hand, and the harbingers of a new, ennobled social order on the other. Many of the first generation of European American acupuncturists recall being inspired by reports of Chinese barefoot doctors. In both cases, these Americans romanticized the Chinese much as they would also romanticize teachers from India, Tibet, and Native American cultures. Still, when European Americans first went to China to study Chinese medicine, it was the politicized PRC-TCM they learned and, eventually, brought back to the United States.

It was not, however, the traditional Chinese medicine practiced by older Chinese Americans,ⁱⁱⁱ most of whom worked in the Chinatowns of the United States, and some of whom also had small European American clienteles. These practitioners had learned through lineage systems, often from older generations in their own families and/or in pre-war educational programs in China or countries with large Chinese populations. As European American attention turned to Chinese medicine, some of these individuals

began to teach their methods to European Americans and, in some cases, to establish acupuncture schools. In Massachusetts, when licensing regulations took effect, some of these practitioners were grandfathered in. They were therefore never required to know PRC-TCM and continue to practice their own systems. Some more recently arrived Chinese American practitioners remain outside the domain of legal practice altogether. They cannot document their training, and a lineage background is no longer sufficient for licensure. Most of these individuals practice in Boston's Chinatown. Advertising in local Chinese-language newspapers, their number unknown, they are generally ignored by public health officials, who assume that they are meeting the needs of their own. Some hold second jobs in restaurants and other businesses.

A third group of Chinese American practitioners has come from Mainland China, trained by the state-run schools. Some have spent four or five years in an undergraduate TCM college after graduating from high school, followed by three to five years of clinical training. The training, while including courses in the biomedical sciences, does not cover biomedical clinical practice. Nor is it equivalent to the education received by Chinese students of biomedicine. Graduates qualify as primary health care practitioners with access to Western diagnostic methods (Ergil 1993).^{iv} A second subset of this group includes medical doctors (MDs), graduates from the state-run schools of biomedicine, who often receive some limited training in acupuncture. Upon discovering that recertification to practice biomedicine in the United States requires competing for a place in a residency program (difficult at best, even for graduates of American medical schools) and repeating at least three years of residency, some of these China-trained MDs choose instead to take the state and national licensing exams to become certified as acupuncturists, for which they are usually sufficiently prepared by their training in China. They may draw on aspects of their biomedical education to explain things to patients but can no longer legally practice biomedicine as such. Others leave clinical practice altogether and may seek work as lab technicians.

In Massachusetts, some of these Chinese American practitioners have become teachers at schools like the New England School of Acupuncture, where PRC-TCM is the dominant system taught.^v They find themselves authorities on the one hand, but subordinate to European American administrators on the other. They provide information and skill seen as closer to the source, even as the

European Americans around them modify and formulate their material for an American audience. Thus, questions of power and knowledge invariably work their way into the identity of these teachers and what they teach.

Their identity is also shaped by how European American students perceive them. These students often want reassurance that they are receiving the “highest teachings.” An essentialized assumption of authenticity is often assigned to teachers coming from Mainland China, particularly insofar as such teachers are perceived as closer to some imagined pure source. Some teachers respond by changing their own self-definition. For example, one *qigong* practitioner who came to the United States from Beijing first introduced himself to me as a “*qigong* doctor”—the title he had used in Mainland China to avoid being identified with “superstitious” orientations toward *qigong*. In another discussion several years later, he casually alluded to himself as a “*qigong* master.” Questions of skill aside, it was an astute marketing move. Americans in search of ancient teachings—even as framed by the PRC—prefer to believe they are getting their practice from a master. Yet despite a long tradition in China of apprenticeship to one’s master-teacher, this dynamic rarely characterizes teacher-student relationships involving European American students of acupuncture. (Interestingly, this is more common in the martial arts schools.) More recently, as restrictions on healing practices have loosened in Mainland China, entrepreneurship, lineage teachings, and charismatic inspiration have resurfaced, producing practitioners who operate outside of official structures (Farquhar 1995, 1996). It remains to be seen what impact such figures will have on the American acupuncture landscape.

A standardized American version of PRC-TCM remains the dominant system of Chinese acupuncture taught in the United States. But a second approach has exercised a greater influence on the field than one would imagine, given not only its minority status but also its smaller number of practitioners, virtually all of whom are European American. Introduced at roughly the same time as PRC-TCM, it attracted people who are now among the older, well respected figures in the field. Developed by an Englishman, J.R. Worsley, “Worsley Acupuncture” is also referred to as “Leamington Acupuncture (LA),” “Five Elements Acupuncture,” and sometimes just “Traditional Acupuncture.”

While one cannot draw absolute lines between these two schools of practice, more Worsley acupuncturists tend to represent an

orientation that foregrounds the emotional and spiritual experiences of both the practitioner and the patient. Insofar as many non-Worsley practitioners also value this orientation, Worsley acupuncturists are respected for privileging it in their work. This is not to say that Worsley practitioners avoid TCM altogether. They cannot. In order to be licensed, they have to pass state and national exams based on TCM theory and practice, for which they usually take an exam preparation course. Some also choose to learn aspects of other schools of practice to supplement their own training.

The other significant acupuncture practices include Japanese, Korean, and Vietnamese styles (whose practitioners must also learn enough TCM to get through the licensing process) as well as two French-based systems. Of the latter, the first is a highly simplified version of ear-point acupuncture demonstrated to be effective in drug-detox programs. The second is a short course designed for physicians, which involves workshops and correspondence components. Among the European American practitioners, other holistic modalities used in conjunction with acupuncture include naturopathy, homeopathy, psychotherapy, craniosacral therapy, zero energy balancing, and vitamins. Few Chinese American practitioners use any of these supplementary practices and, depending on their own level of acculturation, look askance at the European Americans who do. In contrast, the Chinese Americans may use *tuina* (a form of massage) and/or *qigong*—practices that some European Americans also employ.^{vi}

Most European American practitioners neither speak nor read Chinese and feel no need to do so; rather, they locate themselves in the field of what has come to be called “American acupuncture,” and they rely, for the most part, on translated texts. While translated resources do not begin to approach the total number of texts in Chinese, key sources and textbooks from the PRC medical school system have been translated into English, as have classical texts like the *Huangdi Neijing* (*The Inner Canon of the Yellow Emperor*). These practitioners do not define themselves as scholars or historians but as holders of a working knowledge that approximates aspects of the curriculum in Chinese medical schools. In addition to working with teachers from Mainland China, who serve as cultural brokers, some also seek opportunities in Mainland China by participating in internship programs sponsored by the PRC government in an attempt to acquire first-hand experience of Chinese clinical settings. European American practitioners frequently understand themselves

to be generating a new version of an older system into which they have introduced elements that do not necessarily characterize PRC-TCM (Barnes 1998). The efforts of these different stakeholders constitute parts of the process by which acupuncture has become a medical system with a worldwide distribution adapted to local conditions (Last 1990).

THE PROCESS OF PROFESSIONALIZATION

Initial Reception

Challenges to existing configurations of professional practice may arise from peripheral groups present in the larger medical landscape that seek to create new openings for themselves. Such challenges can also be introduced by practices transplanted from other countries, especially if the new practice seems to point to a vacancy in that larger landscape, whether previously noticed or not (Abbott 1988). In 1971, when James Reston published an article in the *New York Times* about his experience of acupuncture, almost overnight the news prompted a swell of public interest. American physicians faced the challenge of explaining the modality to a fascinated public when, in fact, they had no idea how to do so. The biomedical community reacted by pursuing two measures. The first involved asserting control over acupuncture's knowledge base through the demand for research and clinical trials; the second entailed regulating lay practitioners—another form of social control (Wolpe 1985). To establish the first kind of control, acupuncture had to be assessed according to the models formulated by biomedicine. Because physicians themselves had seen acupuncture work in practice, they could not reject the modality outright. The challenge was to prove that biomedical measures and paradigms could, in fact, explain what was going on.

To do so, the entire theoretical framework of *traditional* Chinese acupuncture had to be replaced. . . Biomedicine had no means of assessing the validity of these cultural models. Traditional acupuncture theory and treatment philosophy was therefore all but discarded, and acupuncture analgesia/anesthesia—a very small part of traditional acupuncture's therapeutic claims (acupuncture anesthesia was not used in China until the 1960s)—was presented as acupuncture's only true potential contribution to Western medicine. (Wolpe 1985)

Having simplified the technique and minimized its claims, physicians then argued that acupuncture was not as broadly effective as

was initially imagined, that it posed no significant challenge to the biomedical model, and that physicians were best qualified to evaluate, explain and, oversee it. Despite a flurry of studies and articles during the 1970s, by the 1980s the reduction of acupuncture to a modality whose usefulness was relegated to the area of pain control, along with the stripping away of its explanatory paradigms, resulted in the subsiding of research interest on the part of the biomedical community. Many physicians concluded that acupuncture had little contribution to make to their medical worldview.

To control the actual practice of acupuncture, U.S. physicians argued that it should be categorized as an experimental procedure^{vii} and that it should only be performed in a research setting either by a doctor or under a doctor's supervision. In states like Massachusetts, the supervisory rule remained in place for years. Until 1999, when it was repealed, the law required any patient seeking the help of an acupuncturist first to receive a biomedical diagnosis for his or her condition. Still, by appearing to support research, and by creating structured channels through which to engage with this foreign modality, biomedical authorities could claim that the playing field was not only level but also open to new approaches.

The First Steps Toward Specialized Training

By 1985 sociologist Paul Root Wolpe drew the grim conclusion that acupuncture was on its way to being finished off in the United States. What was not yet apparent, however, was the degree to which laypeople had begun to develop their own training programs, to set up practices, and to develop a strong popular following. These early students and practitioners often saw the study of acupuncture as part of a broader cultural stance of resistance in the pursuit of alternative ideals. They saw it as, if anything, an anti-profession:

We were middle class kids, a lot of us. It was illegal as a practice, and we thought we would never make a living at it. I practiced out of a back room of the bookstore. It was something of an outlaw role. Having gone through our early adult years as outlaws with a feeling of rejection and of not belonging, we probably outlawed it more than it needed to be. But without outlaws, nothing new comes into the culture. (Bob Felt, Publisher, *Redwing Books*, personal communication, 1994)

This process took place in the broader unfolding of what has since come to be called the "New Age." Practitioners often built followings

by word of mouth, few of them advertising or going beyond listings in telephone directories. It was the growth of informal popular support that functioned as a first step toward "professionalization from below," an ad hoc grass-roots version of legitimacy (Kunz and Kunz 1998; Last 1990). These patients felt that, by focusing on aspects of the person that frequently remained outside of biomedicine's analytical framework, acupuncture was addressing a vacuum in biomedical care. This version of legitimacy was, therefore, at odds with the top-down sort.

The earliest training in acupuncture in Massachusetts came about when attempts by a small group of European Americans to start an acupuncture clinic in California folded due to stringent state regulations. Dr. James Tin Yau So, a student of the medical reformer Cheng Dan'an,^{viii} had been recruited from Hong Kong to come to California in 1973 and help set up an acupuncture clinic. However, when he and his supporters discovered that they would be able to practice only "in an approved medical school for scientific research, under the supervision of a licensed physician" (Tu 1999:21), they decided (in 1974) to move to Massachusetts, a state permitting a less regulated practice of acupuncture (albeit within the constraints of a prior physician's diagnosis).

Once there, they found little interest in a clinic either on the part of patients or on the part of the biomedical community. Dr. So began to give classes on acupuncture to some 30 students. Because few texts were available, students learned from his lectures (which were eventually edited and made into a book) and through books imported from England. (Dr. So claimed that the PRC version of TCM was no different from that which he was teaching.) Originally called "the James-Steven School," after Dr. So and another of the founders, in 1975, when the school managed to secure the type of accreditation used by trade schools, the name was changed to the New England School of Acupuncture (NESA). This put acupuncturists in the same class as barbers and beauticians. The first classes were offered in 1976, training lasted for one year, and the first class graduated in 1977. The students in this class received diplomas but no other graduate degrees.

In the meantime, a small number of Americans (like Ted Kaptchuk, Dan Bensky, and John O'Connor) went to China to pursue training. Kaptchuk then went to Boston, where he became involved in the early phases of NESA and began teaching the version of PRC-TCM theory he had learned, actively criticizing schools

such as Worsley's (a position he has since reversed). Kaptchuk's lectures were the basis for the one book on Chinese medicine that is probably better known than any other in the country, *The Web That Has No Weaver*. Bensky and O'Connor translated and published a leading acupuncture textbook entitled *Acupuncture: A Comprehensive Text*. Bensky, with other authors, published additional textbooks that became standard in American acupuncture schools and, with O'Connor, went on to found Eastland Press, a leading publisher of works on Chinese and other Asian medical systems. In general, these early teachers presented TCM as a homogenous system, despite its actual hybridity in the different regions of the PRC. This appearance of homogeneity contributed to American consumers' perception of TCM as a clear-cut alternative to biomedicine.

Over time, additional teachers were hired at NESAs, some of them former students and some of them graduates of PRC-TCM training in China. The early curriculum reflected the specialties and interests of the different instructors. By 1987 the school had expanded the program to two years, with an optional two-year postgraduate program in Chinese herbal medicine. Through the combined effect of European American teachers and English translations, a practice known as "American acupuncture" began to emerge. What had functioned as a system of apprenticeship under Dr. So shifted to increasingly formalized curriculum, standards, and testing.^{ix}

This formalizing of training came much closer to the dynamic of professionalization in which a group reserves for itself a specialized body of knowledge through the development of training facilities and an organized system of conventional training (Caplow 1966). The skills learned take on the appearance of measurability and comparability, becoming marketable commodities. Excellence comes to be equated with standardized units of training and corresponding examinations (Larson 1977). The resulting knowledge and related skills function as screening mechanisms by which to determine who can and cannot claim mastery over the practice (Friedson 1994).

Further Steps: Professional Associations, Credentialing, And Licensing

Even though acupuncturists in the United States could not operate outside of the circle drawn by biomedical authority, they could seek to expand their control as fully as possible *within* that circle. In the sociology of professionalization, it is well recognized that an

important step involves the forming of professional associations so as to define and protect a group's interests (Carr-Saunders 1966). As acupuncture gained popular legitimacy, many of the European American practitioners—themselves from middle-class backgrounds—reexamined their cultural role, their identity as practitioners, and their place in the larger cultural field of American medicine. At stake was the question of status and legalization. In 1983 the Massachusetts Association of Acupuncture and Oriental Medicine was founded to represent the interests of acupuncturists throughout the state. A parallel organization, the Oriental Medicine Practitioners of Massachusetts, was also established, with a membership of mostly Chinese Americans. Due to language barriers, only a few members of the one group also belonged to the other. The eruption of new political issues down the road would lead to the organizing of additional associations.

If, as Weber (1978) observed, the most common form of legitimacy today derives from the belief in legality, then state-sanctioned professional credentials become a key objective. Friedson (2001) goes further, arguing that the state holds the ultimate power to establish professionalism. Certification by the state affords legalized status to a group, allowing it to assert its power to restrict other contenders for legitimacy. In 1985 Massachusetts acupuncturists succeeded in lobbying the state legislature to pass a statute establishing acupuncture as a licensed profession under the auspices of the state's Board of Registration in Medicine, which would also oversee a new committee on acupuncture. The committee was charged with the ongoing task of reviewing educational standards and licensing requirements, and it began licensing practitioners in 1988. By then, NESA's program had expanded to three years.

This statute and the committee were both seen as significant accomplishments by acupuncturists within the state insofar as they enabled them to secure a limited degree of autonomy and freedom to control their work—both hallmarks of professional status (Larson 1977; Friedson 1994). If, as Abbott (1988) suggests, professions represent domains of jurisdiction over certain kinds of work, then we can see this licensing in acupuncture as having established a permeable jurisdictional area *within* the purview of biomedicine (whose physicians were allowed to practice acupuncture without any license other than the MD degree) while also preempting anyone else's right to practice.

The actual criteria for licensing reflected the hegemony of the American version of PRC-TCM, which became the foundation of examinations at both state and national levels. Such an imbalance of power may characterize one subgroup's success in determining how a profession will be defined. Here, the identification of TCM with developments in Mainland China contributed to the system's being represented as the most up to date. Although the privileged position of TCM succeeded in handicapping other schools of practice in the licensing process, it did not prevent anyone from studying other systems; it merely added the inconvenience of also having to take TCM exam-preparation courses.

The licensing criteria did, however, relegate many of the lineage practitioners in Boston's Chinatown to an illegal status, particularly as the requirements eventually included a BA degree and graduation from a certified acupuncture school. As a consequence, these practitioners could not pursue a stake in the burgeoning complementary/alternative medicine market but had to restrict their practices as described above. The exclusion of these practitioners served multiple interests. First, it served embedded biomedical interests by confirming a dominant model of the professional and excluding the alternatives, and by positioning licensed acupuncturists under the governance of the State Board of Medicine. It served the interests of European American acupuncturists, at the expense of the older lineage systems, by making their definition of legitimate practice look more credible to the state board. Finally, by restricting competition, it served the interests of Chinese American practitioners who had either been grandfathered in by being part of the group that pushed for licensing or who were later-comers who had trained in formal programs in China.

Much of this process is about the possession, management, and control of knowledge gained during the years one spends in training and internship—all key elements in the consolidation of professional status in culturally recognizable ways. Indeed, a group's related power cannot be separated from the ways in which such knowledge is valued or not valued by the culture. There may not be an exact fit between the knowledge required by the credentialing process and the knowledge required for the actual work one is to do, but this disparity "may reflect institutional processes more than functional necessity" (Friedson 1994:112–113).

The Wars of the Science Curriculum: A Case Study

Over the years, as different faculty came and went, NESA sustained PRC-TCM as its core curriculum. In the early 1980s it not only added a program in Japanese acupuncture but it also added courses surveying “medical sciences” in order to give students an overview of biomedical care and a preliminary foundation from which to communicate with biomedical clinicians. Ironically, it was not uncommon for students to enter the study of acupuncture as a form of protest against biomedicine. For many, therefore, studying anatomy seemed irrelevant. Nevertheless, having science courses in the curriculum created the impression that the school now came closer to teaching a recognizably “medical” course content.

Few teachers or students knew that, throughout the 20th century, efforts in China to legitimize acupuncture—long seen as a lower-class medicine—had included the selective and politically motivated incorporation of Western anatomical drawings into Chinese medicine textbooks (Andrews 1994). The different moves made by the PRC to integrate biomedical and traditional medical systems were another step in this process. Nevertheless, European Americans who identified with the counter-culture were rarely aware of this attempt to look more “scientific” nor did they understand that “science” in the PRC context frequently referred to the science of Marxist analysis. Virtually no one knew that the prominence given to acupuncture in the United States represented an inversion of its lower-class status vis-à-vis herbal medicine throughout Chinese medical history (Andrews, forthcoming).

Yet practitioners in the United States have not been able to completely ignore the legitimizing seal of scientism. This is not a new phenomenon. In the 19th century, advocates of practices as diverse as homeopathy, vegetarianism, herbalism, spiritualism, and Christian Science (the latter the most obviously) all laid claim to being scientific. Across the turn of that century, “science” became even more firmly entrenched as the core of cultural legitimacy. In 1933 Carr-Saunders and Wilson (1933 [1964]:497) described many professions of the day as “based upon sciences; and nothing, short of the onset of a glacial age in the history of human mental activity, could now check the onward march of these sciences.” Even now, practices such as chiropractic— aspiring to substantiate their status against the backdrop of biomedicine—try to show that the science requirements in their curriculum correspond to those of biomedical

schools (Coulter et al. 1998). Others, such as reflexology, define themselves more vaguely as a "scientific art" (Kunz and Kunz 1998). It is within this context that science and, more specifically, science courses became an arena for the acupuncture wars.

By the early 1990s NESAs decided to pursue the power to grant a master's degree instead of a diploma. In 1993 the Massachusetts Higher Education Coordinating Council determined that, to secure such authorization, the school would have to increase the presence of biomedical disciplines in its curriculum by adding courses in biology, physics, and chemistry. Several members of the Committee on Acupuncture (themselves acupuncturists) submitted a proposal to increase the number of required classroom hours in science to 600 for all acupuncture students. This recommendation translated into roughly 14 courses in areas such as pre-calculus, physics, psychology, inorganic and organic chemistry, biochemistry, microbiology and pharmacology taken either at the undergraduate level (prior to entry into an acupuncture program) or in tandem with one's acupuncture training. The proponents justified the proposal by arguing that a stronger background in science would increase the safety record of acupuncture in the state, raise standards of training, and enhance the likelihood of coverage by third-party payers. They may also have hoped to create a curriculum they thought would further resemble that of those in schools in China.

Response to the proposal was swift and heated. Opponents argued that such an increase exceeded the requirements set by all the other states. Not only would students in Massachusetts have to spend up to two years in biomedical science courses but anyone licensed under the regulations of other states would also have to take at least one year of such courses in order to qualify for licensure in Massachusetts. The policy would have an exclusionary and protectionist effect. Only primary care practitioners—which acupuncturists were not—had such stringent science requirements. Moreover, given that practitioners in the state already had an excellent record, the increase could not be related to a gain in public safety. Opponents of the proposal argued, too, that to assume that an increase in required science courses would lead to third-party payment represented a false equation. They questioned linking the raising of standards to issues of reimbursement in any way.

The real issue involved the hope of enhancing acupuncture's position in American health care. To do so, it was argued, required interacting more effectively with doctors by increasing acupuncturists'

familiarity with biomedical language and norms. That this kind of scientizing has not generally achieved these ends for chiropractors did not seem to act as a deterrent (Wardwell 1988). Some acupuncturists wanted to pursue full status as primary health care providers—a goal that sometimes included discussions of developing doctoral programs so that practitioners of Chinese medicine could also be “doctors.” One contingent asserted that acupuncturists should learn to speak “biomedicine” well enough to be able to order biomedical tests and read the results. Others felt that the only reason to become familiar with biomedical terminology should be to facilitate the process of relating to—and not of becoming—biomedical caregivers. To this end, they argued, what would be most useful would be courses geared to students of Chinese medicine and familiarizing them with the basic constructs and terminology of anatomy, physiology, and some of the clinical sciences.

Advocates of the increase in science course hours represented the position adopted by the Massachusetts Association of Acupuncture and Oriental Medicine, which, until that point, had functioned as a statewide umbrella organization. They also had the support of the national American Association of Acupuncture and Oriental Medicine and, in particular, its president, Harvey Kaltsas, an early graduate of NESAs. Acrimonious disputes ensued. In the process, practitioners who questioned the proposal discovered that the Massachusetts association was challenging their professional competence and credibility in mailings to its membership. Attempts to discuss the issue both within the association and with some of the board members of the state Committee on Acupuncture were rejected. Increasingly, it appeared that those who failed to adhere to the official line would be subject to private and public censure. It was a dramatic case of a professional association attempting to marginalize dissent and to impose its own definition of required knowledge directly in relation to existing social processes of legitimacy.

As a result, a separate group, calling itself the Acupuncture Society of Massachusetts, organized toward the end of 1993 and put out its first newsletter in January of 1994. Parallel debates on the national level led to the formation of a new organization—the National Acupuncture and Oriental Medicine Alliance, now usually referred to simply as the National Alliance. The Alliance claimed that the American Association of Acupuncture and Oriental Medicine had ceased to represent the diversity of practices in the United

States. Members of the Acupuncture Society of Massachusetts put pressure on the state to accept the national standards for science course requirements in acupuncture schools, which were less demanding than were the requirements proposed by the Committee on Acupuncture. The lower requirements were eventually adopted, thereby enabling NESAs to grant a master's degree.

Deeper issues remained unresolved, among them the question of diversity of practice. The committee's proposal had been read by many as an attempt to standardize acupuncture education, which, in itself, is the sort of strategic move that may arise in the process of professionalization. Opponents foresaw, however, that this approach would lead to the indirect suppression of the variety of acupuncture traditions in the United States in general and in Massachusetts in particular. Nor did the debate divide strictly along the lines of TCM and other practices; rather, it represented differing definitions of what an acupuncture professional ought to be.

IN THE BROADER SOCIAL FRAME

Flux in Definitions of Biomedical Professionalism

The tensions in the professionalizing of acupuncture have not taken place in a vacuum. Any system of healing operates within, and in response to, a larger national medical culture—"the national arena in which competition takes place, with professionalism as one factor in that competition" (Last 1990:351). Surrounding the debate about acupuncturists' identity is the greater American health care system, within which another debate is taking place about the professional identity of the physician.

Until the 1970s the field of American biomedicine had successfully defined itself as a universally valid system, as is evidenced by its generally being known simply as "medicine." Its authority had been buttressed by Supreme Court decisions that had defined it as neither a business nor a trade, had given it immunity from anti-trust suits, and had upheld the exclusivity of its license and of its monopoly and control over practice (Friedson 2001). During the 1970s, however, various social groups challenged physician paternalism and the restricted access to the profession for women and persons of color. Physicians encountered growing cultural distrust from a better-informed client population, influenced by the patients' rights movement and expressed through increased

malpractice suits. Some of the patient population became ambivalent not only about doctors but also about the biomedical science they practiced. Thus, the biomedical profession simultaneously experienced itself as culturally powerful *and* under ongoing attack.

Over the following decades, more doctors were working for health-care corporations than were going into private practice—a phenomenon sometimes referred to as the “proletarianizing” of biomedicine (Kimball 1992). Their cultural authority was further eroded by the rational-legal administrations of the Health Maintenance Organizations (HMOs). This process exemplified certain aspects of Weber’s (1978) model of the large, modern organization. Formal rationality of this sort works “to eliminate as much discretion from work as possible, and to employ fixed and objective criteria for evaluating it” (Friedson 1994:212).

The valorizing of efficient practice now not only pervades biomedical practice but has also come to be “a central value in the social-structural legitimization of American professions” (Abbott 1988:193). Insofar as the assessment of efficiency requires observable results, the development of validated outcome measures becomes all the more important. Less tangible or quantifiable outcomes—such as empathy and interpersonal rapport—thereby continue to be valued in medical teaching and discussion but prove difficult, if not impossible, to measure in ways congruent with the qualities themselves (Abbott 1988). When physicians attempt to implement the intangibles, the constraints on the time HMO reimbursement policies allow them to spend with the patient often compromise even the best of efforts.

Some physicians subvert these attempts to rationalize medical care by refusing, beyond a certain point, to curtail time spent with patients. Increasingly, one sees the relationship between physicians and managed-care plans parsed by doctors in the terms of resistance that once characterized the social protest literature of the 1960s:

What physician...can be dispassionate about the current destruction of our medical family at the hands of profit-hungry CEOs? (Needham 1998:66)

By the mid-1990s, physicians and patients alike are resisting the shackles that managed care appeared to have placed on them. (Bodenheimer 1999:584)

We can, of course, take these statements as the expressions of a professional group fighting the undermining of its own legally enforced monopoly (Larson 1977) and of the right to control its own

work. To say that this is all that is going on, however, is to ignore the importance that professional identity can also hold in relation to a person's sense of self and broader value structures. In addition to asserting the negative consequences of the health care corporation for biomedical practice, some physicians now speak of other core identity elements as imperiled, defining authentic professionalism in terms of the moral commitment to the ethic of medical service and the public profession of this ethic (Swick et al. 1999; Wynia et al. 1999). Such positions also reflect physician recognition of patients' desires not so much for efficient practice as for "a longing to be cared for" (Cowley 2002:50).

Role Definition, Status, and Compensation in American Chinese Medicine

The gold standard of professional medical identity—the biomedical physician—is therefore in flux. Yet this is the health care world within which one contingent of acupuncturists wants to create a formal place for practitioners of Chinese medicine—a move that must be interpreted in relation to that aspect of professionalization involving the social advancement of the group. The goal is the securing of market power, which, this contingent hopes, can translate into social and economic rewards (Larson 1977). This connection between status and remuneration is generally a close one (Carr-Saunders 1966; Friedson 1994).

This connection has led to sometimes bitter debates in both the state and national associations concerning the definition of acupuncture *in relation to* other health care roles in American medical culture. Who, in other words, is an acupuncturist *like*? Although in Mainland China an acupuncturist/herbalist can claim semi-physician status, such neither is, nor will be, the case in the United States (except for physicians who elect to add some form of acupuncture training to their work as biomedical specialists). If one gauges equivalence in terms of training hours—a measurement frequently resorted to in these debates—then is acupuncture training closer to the education involved in becoming a nurse, a physician's assistant, a physical therapist, or some other practitioner (Lipman 1995)? Acupuncturists have asked themselves where they would fit in the biomedical food chain and how that positioning would inform the social perception of their status. Within the hierarchy of the alternative medicine world, they rank high. But if seen as equivalent to a

physical therapist—a role ranking much lower in the biomedical scale—that status diminishes.

The wars over science course requirements led acupuncturists directly into these questions. They pushed practitioners of all schools to look hard at how they wanted to define themselves and at how they wished to be perceived by others. Did they *want* to be classified as primary care givers defined by intensive training in biomedical science? The subtext, for a significant number of them, was the question of what this classification had to do with their own reasons for going into acupuncture in the first place as well as with their own understanding of, and commitment to, Chinese medicine as a system in its own right.

One argument in favor of becoming health-care providers was economic, driven by the social force of increasingly influential HMOs. What had once been an inexpensive alternative—particularly in the 1970s, when much of biomedicine still involved payment out of pocket—had since become relatively costly, compared to the minimal insurance co-payments now generally required by HMO's for visits to biomedical practitioners. (Somehow, the skyrocketing costs of health insurance that accompany small co-pays do not generally enter the discussion.) Some acupuncturists argued that, in order to compete with other modalities as well as with the growing numbers of licensed acupuncturists, they would have to adopt a primary care model of practice. If this were to happen, then practitioners would have to evaluate and diagnose patients, treat and refer them, and follow their progress according to biomedical standards (Lipman 1995).

The counter-argument challenged the motives for defining the acupuncturist as a primary care provider. Would this role actually translate into more money, power, and status? And would the costs outweigh the benefits? This side also argued that, despite their treatments costing more than HMO co-payments, Chinese medicine practitioners still provided care that was relatively low cost and low risk. Insofar as health insurance now covered acupuncture, it was frequently not in the form of full coverage but, rather, in the form of a list of approved providers from whom the patient could receive a discount. The insurance companies, therefore, often paid nothing but created the illusion of openness to complementary and alternative medicine for which the patient still paid out of pocket on top of paying for health insurance. Such policies, it should be noted, continue to restrict use to a largely middle- and upper middle-class

patient population that has already shown a continued willingness to include acupuncture in its budget.

If practitioners were to become primary care providers, then they would be subject to the standards of care (and the rules) of biomedicine. For example, they would be legally responsible for ordering biomedical diagnostic tests and for their interpretation. Moreover, all licensed practitioners would be liable for failure to operate according to these standards of care, whether they wished to define their practice in such terms or not. Should one not order such tests and therefore miss something about the case, then he or she could be charged with negligence and be subject to malpractice suits—a phenomenon currently rare in the acupuncture world. Along with these risks would thus come higher malpractice premiums and related hikes in fees passed on to patients in addition to the costs involved in ordering diagnostic tests.

Many acupuncturists have concluded that the financial consequences of qualifying for third-party payment may not be altogether happy ones. Practitioners will face imposed ceilings on their fees and will be forced to accept whatever rates and terms are approved. Most acupuncturists do charge at a higher rate, meaning that, in exchange for increased patient volume, they would confront a reduction in compensation. In addition, there is the morass of paperwork involved in filing claims and the delays incurred when something is not filled out correctly. The approved indications for acupuncture would probably be limited to a relatively small number of diagnoses, with the number and frequency of covered treatments restricted. Most critical, in some people's minds, would be the constraint imposed on the time a practitioner could spend with a patient—one of the factors most highly valued by both parties. Practitioners, it is often argued, might therefore end up sacrificing their independence to achieve this kind of compensation, the benefits amounting to little more than "fool's gold" (Rothfeld 1996).

Viewed in this light, a strong contingent of practitioners has resisted efforts to fit into the paradigm of the biomedical health-care provider. Many feel that acupuncture itself is complete as a modality and that they would do better to work at rewriting the rules defining the larger system. If forced to adapt to an increasingly biomedical model—and, more specifically, to the financial structures that govern it—they fear that what is unique to Chinese practices will gradually be eroded to the point where the practice becomes a set of techniques divorced from the dimensions of spirit and healing that matter

to them. Here, the personal orientation of some practitioners most frequently finds itself at odds with the medicalized model many of them started out opposing.

Some practitioners identify this situation as a challenge to their convictions about the integrity of Chinese practices in their own right. "It is essential," wrote the editors of the *ASM Newsletter* in 1994, "that we have the courage to continue to enhance our place and reputation in the medical community on the basis of the effectiveness of the form of medicine we practice, rather than by following a medical model which is increasingly being questioned" (Anonymous 1994:4). Or, as one practitioner said to another after a meeting on managed care, "Don't let them turn you into a health-care provider" (Duggan 1999:3).

FROM HERE TO WHERE?

The Pluralism of American Medicines

There has never been a time when American medicine as a whole has not been characterized by pluralism and dissent, with, along the way, a resurgence of the call for the democratizing of medical knowledge (Starr 1982). There is also a rich tradition of vitalism in the United States—a tradition into which Chinese medicine practices have been inserted (Kaptchuk 1996). The experience of postmodernism has not only reinforced the experience of pluralism on multiple fronts but it has also led to pluralism being seen as a positive good insofar as it supports the dominant model of the choice-making individual's freedom to select from a range of options. This pluralism exists in tension with efforts on the part of biomedicine, reinforced by the state, to sustain a hierarchy of privileges at the expense of non-biomedical practices (Last 1990).

In China, acupuncture and herbology are recognized as parts of traditional Chinese medicine. In the United States, however, neither represents a recognized traditional system, despite the presence of Chinese practitioners since the nineteenth century. Thus, efforts by the PRC to integrate TCM into state-run services mean something quite different from the attempts of American practitioners to make a place for themselves in the health care marketplace of the United States. Nor can the latter be fully compared to efforts in other contexts, at the encouragement of the World Health Organization, to

professionalize indigenous practitioners of traditional medicines as a response to scarce health care resources (Johnston 1998).

In some of these other settings, one finds more formally structured systemic interactions (Wexler 1984). As we have seen, in the United States the presence of biomedical science courses in acupuncture curricula represents one intersection, the physician acupuncturist another. An even more striking convergence has come into play since January 1993, when, in the *New England Journal of Medicine*, David Eisenberg and his colleagues published their findings concerning the use of "alternative medicine." The study showed that one-third of the 1,539 adults surveyed had used some form of alternative therapy during the previous year and that the nation as a whole was spending roughly ten billion dollars a year on out-of-pocket costs related to alternative medicines (Eisenberg et al. 1993). Almost overnight, as it became apparent that these therapies were big business, biomedical institutions began to make a place for selected alternative practices, generally in truncated ways.

Acupuncture became a poster child for this change. Article after article in the mainstream press carried illustrations, among which was invariably one of a patient's face dramatically stuck full of needles. Hospital pain clinics began to hire acupuncturists, restricting their practices along the lines of the reductionist, pain-based orientation dating back to the 1970s. Still failing to recognize or understand the paradigms upon which the modality is based, a reductionist version of Chinese medicine was now recognized by hospital and medical school administrators to be a potential source of patient satisfaction and of income. As historian Paul Wolpe (1999:11) observes, "The current rapid change in medicine's willingness to accept alien modalities is a perfect example of how politics, economics, and turf battles underlie so much of the process of presumably 'objective' decisions in medicine and science."

Re-Enter the Clinical Trial

In the process, sectors of the biomedical community have revived the call for alternative practices in general, and acupuncture in particular, to face the test of the randomized, double-blind, controlled clinical trial. In part, this call comes from the genuine conviction that only by this means will the legitimacy of these practices be definitively confirmed. Insofar as the field has tended to attract people who are anti-establishment and anti-research, this has

required some sectors of the European American acupuncture community to confront their own ambivalence toward biomedical models. Yet, with the founding of the National Institute of Health's Office of Alternative Medicine Research in 1993—and the related possibility of grant funding—some of the same practitioners who argued for increased science courses have backed the need for clinical trials of this kind.

Their acquiescence must be seen first in relation to the cultural authority claimed by biomedical science to determine the truth of a thing, to stipulate what does and does not count as both efficacious practice and evidence thereof, and to govern related research funding. But the acquiescence is also a step toward the pursuit of professionalism through attempting to tie in with universities and hospitals and to locate the modality within a research context. What made the challenge to design clinical trials all the more appealing to those who favored the use of a clinical trial model was that, this time, doctors were not the only ones deciding what was to be studied and how the studies were to be designed. Instead, advisers from different alternative practices were recruited as ongoing consultants, and practitioners from many modalities were given the opportunity to present grant proposals for research projects. By 1994 30 proposals had been selected, five of which involved Chinese modalities—acupuncture, “electrochemical treatment,”^x *taiji*, and *qigong*. The studies addressed conditions of depression in women, the shrinking of tumors and the boosting of the immune system, attention deficit hyperactivity disorder in children, mild balance disorders, and reflex sympathetic dystrophy (a chronic disease of the nervous system) (Acupuncture Society of New York 1994). In other words, broader dimensions of Chinese practices had finally entered the research picture.

The Potential Co-Opting of Acupuncture

The cumulative impact of such studies is clear when popular magazines like *Newsweek* feature “The Science of Alternative Medicine” as a cover story (once again illustrated by a close-up of a woman's face stuck with acupuncture needles) and include as a feature story “Chinese Medicine May Have Much to Teach the West” (Underwood 2002). The second edition of *Web That Has No Weaver* now includes an entire appendix summarizing clinical trials related to acupuncture (Kaptchuk 2000).

However, what many who promote the pursuit of legitimacy through the clinical trial do not generally acknowledge—or, in some cases, grasp—is that the undertaking is more complicated than might first appear. The encounter between biomedicine and Chinese modalities over the centuries has repeatedly shown that multiple paradigms are at work and that, insofar as the various paradigms represent mutually exclusive conceptualizations of the body, translation between the two medical cultures is neither simple nor even necessarily possible. For example, if there is one root common to the different Chinese modalities, it is *qi*—the vital force that is the basis of acupuncture theory and treatment, of herbal medicine, and of the internal dimensions of the martial arts and *qigong*. *Qi* itself is frequently rendered as “energy,” a mistranslation that began with French advocate Georges Soulié de Morant and has since been adopted by many complementary and alternative medicine (CAM) practitioners. *Qi* has always proved problematic for biomedical physicians because the meridians—the *qi* pathways—do not correspond to any yet known blood, lymphatic, or nerve systems. Even the notion of “energy” is difficult to locate within the biomedical paradigm, as the long-standing ambivalence toward vitalist practices in American medical history illustrates.

Furthermore, insofar as it requires the reduction to a single etiological factor and corresponding single intervention, the very premise of the double-blind randomized control test (RCT) is incompatible with Chinese medicine theories and practices. Many acupuncture systems treat symptom clusters not assigned significance in biomedical diagnosis. In addition, the insertion of the needles during treatment is part of the diagnostic process as the practitioner observes the patient’s responses and continues to modify treatment accordingly throughout. It is thus a theory applied over the course of a treatment, during the process of which the diagnosis undergoes refinement (Farquhar 1995).

A second issue involves the ability of the RCT to assess acupuncture. As Ted Kaptchuk commented to me:

Five hundred RCTs have been done to test acupuncture. If you count up the positive and negative results, it turns out to be fifty-fifty. It’s random, like flipping a coin. Usually, when you get this kind of outcome it’s explained by saying that you didn’t have good trials. But a different question is whether the method is sensitive enough to consistently detect a clear and persuasive outcome. There are many problems with testing acupuncture, because it’s a

device and not a pill. The example no one's noticed in relation to the placebo effect of devices is that you consistently get fifty-fifty outcomes. This has been shown to be the case with Tens Units, and with cortisone shots, for example. There are questions of sensitivity and methodology. It raises the broader problem of how you test devices. (Personal communication, 1999; See also Kaptchuk et al., 2000; and Horrigan 2001)

The challenge confronting biomedical science has been what to do with this kind of anomalous information. The use of the biomedically based clinical trial may work to the disadvantage of practices like acupuncture. Biomedicine, when faced with a paradigm that does not fit its understanding of how things work, has tended to look for whatever pieces of that paradigm *can* be fitted into its own model and to reject the rest. Either that, or it has found ways to absorb ostensibly contradictory language into its own explanatory system.

Revolutions in dominant paradigms tend to occur only when they are no longer able to reconcile internally generated contradictions or when those contradictions persist for too long. The *qi* paradigm is nowhere close to provoking such a revolution; rather, it is more likely that the call for evidence-based outcome studies will reinforce the trend in biomedical circles to conceptualize acupuncture only in the narrowest of terms. The assumption is that CAM therapies will have to fit into the paradigms of biomedicine. Some practitioners recognize this possibility and are just as skeptical of this goal as they are of becoming full-fledged health care providers. They worry that it will lead to acupuncture being subordinated to paradigms with which it has little in common.

Wolpe, looking at these renewed efforts to pull acupuncture under more direct biomedical control, points to a corresponding development. Observing that some CAM therapies are, themselves, becoming increasingly corporate and are functioning as "just another value-added service to market or consumers," Wolpe (1999:12) projects that CAM practitioners will soon be "just another set of allied medical personnel under the direction of a primary care doctor, and will lose much of what made their care so desirable in the first place." When biomedical institutions themselves sponsor such practices, Wolpe points to the loss of an earlier cultural symbolism, when alternative practices represented a rejection of biomedicine. At stake, according to this argument, is the routinizing of what once held the cultural cachet of resistance.

It is telling that the 1996–97 edition of the U.S. Department of Labor’s *Occupational Outlook Handbook*, which presents forecast data for hundreds of occupations, for the first time included acupuncturists among professions/occupations related to that of physicians (Leicht and Fennell 2001). Although not classified as a biomedical practice, acupuncture had achieved sufficient authority to be listed, thereby potentially and more overtly encroaching on the turf of the physician. If jurisdictional jockeying is intrinsic to the process of professionalization, then the folding of practices like acupuncture into the purview of the NIH—even though through NCCAM—can be interpreted as a related boundary skirmish (albeit one that, as we have seen, not all acupuncturists oppose).

CONCLUSION: THE POTENTIAL FOR RESISTANCE

Holistic Alliances

So far, I have addressed some of the ways that biomedical standards have filtered into the professionalizing of acupuncture. But just as this professionalization has not taken place in a vacuum, neither has a rethinking of what it means to be a biomedical physician. In addition to the uncertainty concerning professionalism discussed above, there has also been concurrent cross-fertilization between doctors and the holistic models that pervade the broader culture. Davis-Floyd and St. John (1998) suggest that what we now see in practice are three paradigms of health care along a continuum. These they define as the technocratic model, the humanistic model, and the holistic model.

Technocratic medicine, or “the technomedical model,” has a value system oriented toward high technology, economic profit, and patriarchally governed institutions, and its criteria are rooted in biomedical science. It is in this domain that we find the stereotype of the doctor represented as lacking in empathy and compassion, even though he or she may exercise considerable mastery over these other kinds of knowledge. On a popular level, it is also the most negative stereotype about physicians.

The humanistic model refers to doctors who practice conventional biomedicine but according to

the relationship-oriented humanistic model of medicine, the principles of balance and connection that underlie it, and the balanced empathic mode of

thinking that fosters it. This more conservative model does not demand radical alterations in the technocratic approach, but rather softens its hard edges, adding warmth, compassion, conversation, and individualized treatment to patient care. (Davis-Floyd and St. John 1998:10)

The holistic model, in contrast, not only includes the relational dimensions of humanistic medicine but also favors paradigms borrowed from the different alternative modalities—healing the whole person in a whole life context and introducing alternative techniques into the doctor's own practices. An analogy would be 19th-century regular physicians who also practiced homeopathy (and were excluded from the American Medical Association for doing so). The values of practitioners defining themselves as holistic are frequently articulated in “affective and inclusive terms like balance, relationships, connection, energy, rhythm and resonance” (Golby and Hopper 1999:45), which do not translate well into the language of the technomedical model. One finds an emphasis on the practitioner defined as “healer.”

By describing these three orientations as plotting out along a spectrum with many overlaps and blurring of boundaries, Floyd-Davis and St. John remind us that, while there may rarely be a pure type, there are discernible dispositions toward practice. More to the point, I suggest that we find similar orientations among acupuncturists. There are those, for example, who want to restrict their interventions to the technical aspects of needle insertion, seeing a need to address the emotional, psychological, or spiritual dimensions espoused by the holistic model. Although they differ from the technomedical physician in not aligning themselves with biomedical science, their orientation toward their patients is similar, particularly in the maintenance of a greater professional distance (McGuire 1988). There are also acupuncturists who resemble the humanistic model in that they don't feel prepared to delve into all the dimensions of the “whole person” paradigm but who nevertheless rely on a combination of technical expertise and compassionate care.

The greatest intersection and blurring of boundaries, both in terms of self-definition and approach to care, occurs within the holistic model. These are the physicians whose orientation most closely resembles that of some CAM practitioners. This does not mean that the holistic physician is entirely prepared either to accept the alternative construct of the body as energy or to renounce biomedical science. Indeed, one difference between holistic doctors and

non-physician CAM practitioners as professionals may lie not only in the nature of their training but also in their position relative to biomedical science, a field in which the doctors are invested both in their teaching and research (Davis-Floyd and St. John 1998). For that matter, even physicians who may not think of themselves as “holistic” *per se* are increasingly willing to collaborate with CAM providers, and a study at Duke University’s medical school showed that 30 percent of the affiliated doctors were interested in studying CAM therapies themselves (Cowley 2002). Holistic alternative practitioners, on the other hand, may retain prejudices against biomedical science and related practice.

It is this type of physician who is likely to become familiar enough with complementary modalities to recognize the limitations of the RCT model and to call for the development of other models of testing. This shift has, most recently, found expression in a call for proposals from the NIH’s National Center for Complementary and Alternative Medicine (NCCAM), which is run by Stephen Straus, a physician dedicated to evidence-based medicine. In his director’s report, Straus defined as one of NCCAM’s key research principles the study of whole CAM “systems,” a project requiring “creativity and flexibility” (NCCAM 2000a).

Despite the widespread use of traditional, indigenous systems of medicine, most research investigating these systems has stressed minimalist studies of one, or perhaps two, interventions taken out of context and used to treat a conventional medical diagnosis. For instance, there are hundreds of studies examining the efficacy of acupuncture needling, alone, for treating such diseases or conditions as asthma, pain, hypertension, and nausea; yet in real practice, acupuncture would be just one aspect of an arsenal employing, for instance, botanical potions, cupping, dietary changes, exercise, meditation, and moxibustion. . . It is readily acknowledged that inclusion of a complex intervention greatly complicates the design and implementation of a clinical trial, particularly the gold standard of clinical research, the double-blind, placebo-controlled, randomized trial. . . The cultural context in which systems are practiced and studied needs to be considered. (NCCAM 2000b, n.p.)

What remains to be seen is whether the promise of research funding will indeed lead to tests that will challenge the hegemony of the RCT by taking alternative frameworks seriously into account in trial designs.

To the extent that holistic physicians and CAM providers like acupuncturists see themselves as sharing a worldview (if not a medical paradigm), natural alliances are more likely to emerge,

particularly in the pursuit of “integrative medicine,” a vision described as “one health system instead of two, [in which] healers of every stripe will work together while being guided by science” (Cowley 2002:48). This is all the more probable in states with greater numbers of acupuncturists as evidence suggests that practitioners in such settings are able to operate with a high degree of autonomy and a broad range of authority (Cooper, Henderson, and Dietrich 1998). As of October 2002, for example, there are 586 licensed acupuncturists in Massachusetts.^{xi} Partnerships may, therefore, be a likelier model in such settings, without the acupuncturist necessarily becoming a primary care provider (except with regard to specific aspects of Chinese medicine).

The Defense Of Pluralism

While Wolpe (1985, 1999) has projected a fairly dismal future for acupuncture, it is worth bearing in mind that he also anticipated its demise in the face of physician indifference over a decade ago. That earlier projection did not factor in the force of the grassroots support for acupuncture—a domain in the national medical culture that has its own understandings of efficacy and its own criteria in formulating personal and family systems of care. From this vantage point, Wolpe’s current prophecy may not adequately take into account either the social force of popular support for a more holistic version of acupuncture or the stubborn protectionism for diversity at work among both American acupuncturists and practitioners who define themselves in relation to other Chinese healing modalities. There continues to be a large number of acupuncturists who, while they may no longer see themselves as “alternative” practitioners working in opposition to biomedicine, still define themselves as “complementary”; that is, as distinct from biomedical practice but able to work as partners. They are not necessarily willing to give up their stance of opposition to the troubled world of biomedicine—or to its definition of professionalism—which they see their work as representing. Instead, they prefer to generate their own norms and standards, thereby sustaining a dissenting role within the broader domain of medicine (Larson 1977) and defending different visions. Even when concerned with their social status, they also know that there are enough patients interested in what they do, and willing to pay for it out of pocket, to enable them to stand apart from the biomedical reification of their

practice. Whispers of the guerrilla spirit therefore remain alive and well, albeit generally class-bound.

In that spirit, the persisting trend over the last three decades has been to preserve the right of diverse schools of practice to sustain their differences. Both the Acupuncture Society of Massachusetts and the National Alliance were organized precisely in reaction to efforts to standardize practice beyond the basic licensing requirements. Even when confronting pressures to make more of a place for themselves in the biomedical field—pressures that could have led to adopting a dominant model and creating a potentially more unified front—enough practitioners valued diversity that they organized to fight a fundamentally homogenizing stance. The very Declaration of Principles of the Alliance, known as “The Seattle Statement” of 5 April 1997, starts with its first principle: “Respect the broad diversity of Acupuncture and Oriental Medicine” (Acupuncture Alliance 1998:11).

In Massachusetts, the balance might not have swung in this direction if Worsley practitioners had been less influential. Although they represent a numerical minority within the larger acupuncture field, many of them are personally so well respected by other practitioners that their influence far outweighs their numbers. It is worth noting that the Acupuncture Society of Massachusetts has a healthy and even disproportionate share of Worsley practitioners among its members. Moreover, Stephen Birch, one of its leading representatives in the United States, spoke for Japanese acupuncture.

But the debate among acupuncturists over what the profession should look like is far from dead. In the December 1998 issue of *American Acupuncturist Update*—a publication of the American Association of Acupuncture and Oriental Medicine—members engaged in a discussion concerning whether or not *fengshui*^{xii} should be included as part of the practice of Oriental medicine in the United States. Bob Flaws (1998:15), practitioner, author, and head of Blue Poppy Press, defined the parties involved as “all those practitioners who are practicing traditional Oriental medicine...as a secular professional medicine” as distinct from “all those practitioners who practice Oriental medicine as part of a larger ‘spiritual journey to the East.’” This difference, Flaws went on to argue, “drives to the very heart of many of the problems which beset our profession today” (15). Both groups, he suggested, must make the best of their differences and work together. But their interests, as he defined them, are not the same:

Let me say at the outset that I too most definitely began my study of Chinese medicine as a part of a larger journey to the East. . . I too came to Chinese medicine out of a primarily spiritual need and interest. That being said, the more I have learned about Chinese medicine and the history of its development (especially after I learned to read Chinese for myself) and the more I have learned about being a professional health care practitioner in contemporary America, the more I appreciate and endorse a purely professional approach to this medicine. (15)

Toward those who continue to identify the practice of one of the Chinese healing traditions as integral to the spiritual part of their lives, Flaws adopted the tone of the now enlightened figure, for whom such identification is irreconcilable with one's status as a professional:

Those interested in furthering this practice as a secular, professional medicine want to see the institution of definite standards of care *and* standards of scholarship. Such standardization includes not only diagnosis and treatment but terminology, scholarly procedures (such as peer review, footnotes, and bibliographies), research protocols, and even such real-life, nitty gritty issues such as dress and personal hygiene. Unless we move in the direction of such standardization, we cannot have peer review. Without peer review, we cannot have third party payments and we cannot participate in PPOs, HMOs, etc. Many of us are seriously concerned that, as we become more visible and attractive to mainstream Americans and, therefore, move into the mainstream health care delivery system, those other professionals there before us will find us a group sorely lacking in our (secular) professionalism. (15)

As we have seen, the moves urged by Flaws are all designed to consolidate a more conventionally defined professional standing in the shadow of biomedicine, according to criteria formulated by other disciplinary bodies. At stake is acceptance by the "other professionals there before us," for whom the failure to evidence full secularism will represent a corresponding failure to divorce acupuncture and related practices from potential accusations of superstition and quackery.

Not all practitioners accept the need for, or even the desirability of, this definitional divide, and this has led to an unresolved debate over how to conceptualize acupuncture as an American profession. Some acupuncturists have attempted to bridge—or at least to camouflage—the differences. The Spring 1999 issue of the *Acupuncture Alliance Forum*, the newsletter of the National Alliance, announced the outcome of negotiations with what has now come to be called the American Association of Oriental Medicine (formerly

the American Association of Acupuncture and Oriental Medicine). The two organizations agreed to hold their annual meetings at different times rather than on coinciding dates, which used to force members to choose one over the other. They acknowledged the differences in their respective visions but now define these as complementary rather than as contradictory.

The National Alliance also acknowledged “the right of other practitioners of AOM [American Oriental Medicine] to practice according to their tradition, scope of practice, and education” (Editors 1999). Each sort of practitioner should “do so using professional clinical-based standards that provide all recipients the best chance for optimal outcomes” (3). The emerging model, therefore, is one of a community of many “houses” (or a mansion with many rooms), each one with its own criteria for membership and with elected representatives sitting on a central board. Gone for now are the vituperative diatribes and the acrimony that, for several years, characterized interactions between the two organizations. As the former president of one of the state organizations dryly commented: “It’s really quite remarkable how short people’s memories are turning out to be” (personal communication, 1999).

The new model proposes to support each “house” defining its own professional criteria for its own version of “Oriental” medicine (rarely do acupuncturists evince awareness of the political complications attaching to the term “Oriental”). Therefore, what we do not yet know is how the tension pointed to by Bob Flaws—one that, to some extent, cuts across all the organizations—will be worked out. While individuals of all stripes may be able to subscribe to the ideal of developing standards of practice-related competency, the different understandings of what this competency actually means remain unreconciled. TCM continues to be the dominant system represented in the state and national licensing exams for acupuncturists. At the same time, the different schools of practice persist, as do the TCM exam-preparation courses.

This lack of resolution illustrates the transience of any one definition of professionalism and points, instead, to the systemic dynamics that characterize the *process* of definition within the context of changing social factors. Still, if any force is likely to hold at bay the full co-optation predicted by Wolpe, it will be the definitional messiness preferred by the discipline itself, along with the resourcefulness of acupuncturists to appropriate the professionalization process for their own ends. We might do well, therefore, to

describe the current situation not so much as an end to the acupuncture wars as a working truce.

It could be argued that the process described above should be seen not only as the Americanizing of acupuncture but also as the biomedicalizing of the modality. In particular, the reality of having to become a profession within a dominant biomedical sphere might suggest that acupuncture has survived by submitting to the authority of biomedicine. And yet, it is still widely held in the acupuncture community that the real source of the community's legitimacy resides in its grassroots support and clinical practice, independent of legitimacy bestowed by biomedical science. In this respect, many remain suspicious of having too great a dependence on the biomedical community and capitulate to its structures and requirements only insofar as it is strategically necessary. The strategy appears to have paid off. In September of 1998, for three reasons the Massachusetts Board of Medicine advocated the creation of a separate and independent Board of Acupuncture:

First, the board felt they were not sufficiently knowledgeable about acupuncture to be regulating us and we would do a better job with our own board. Second, since the dropping of the MD diagnosis/referral there was no longer the need for such oversight, and third it may not be a good use of their staff's time and budget. (Duggan 1999:3)

More than anything, the change represents a reassigning of jurisdictional authority, with the physician contingent stepping back and redrawing the lines around the knowledge over which it claims control. Insofar as a profession can not claim governance over too many competencies (Abbott 1988) without its domain coming to appear too diffuse and even abstract, the move represents not only the acceptance of the NCCAM statement but also a rethinking of which jurisdictions it is important to control. Some acupuncturists worried that, once outside of the Board of Medicine, it might be easier to eliminate the Board of Acupuncture; however, to date, no such thing has happened.

A significant number of practitioners continue to view their work as a therapeutic system in opposition to the biomedicalization of healing and, therefore, see it as a principled battle. It is worth noting that, through its continuing education program (the curriculum outside of the curriculum required for licensure), NESAC continues to offer courses in such topics as *fengshui* geomancy. Other schools' continuing education programs include courses on the divinatory

system of the *Yijing* (*The Classic of Change*), hardly an approach likely to be perceived by physicians as compatible with biomedical science or the role of a health care professional. The inclusion of these kinds of courses under the rubric of “continuing education” again suggests that, although there is a strategic acquiescence to dominant criteria (in the form of the required curriculum), there is also an underlying commitment to other ways of healing.

In the case of American acupuncture, professionalization has coincided with cultural translations of the modality by a generation of European Americans motivated not only by the desire for status but also by an ideological commitment to diversity, autonomy, and holistic paradigms that favor paying attention to the multiple dimensions of human experiences of illness, health, and healing—a commitment that some physicians share as well. For some, this orientation constitutes a principled article of faith. Economic and social interests notwithstanding, many are willing to go only so far in compromising its ideals.

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NOTES

- i. Acupuncture had entered American medical practice in limited ways in the 1820s, as American physicians observed its more widespread use in England, Scotland, and France (See Barnes, forthcoming a).
- ii. Data for this article was gathered between 1991 and 2000 through 115 semi-structured interviews with sixty-five practitioners of some version of acupuncture and related modalities. Fifteen were Chinese American (five women and ten men); forty-six were European American (nineteen women and twenty-seven men). Other racial-ethnic groups included one Japanese man, one Korean man, and one African American man. Interviewees were initially selected through listings in the *Yellow Pages* and then through word of mouth (the method by which clients usually find practitioners). These interviews were conducted in

- practitioners' homes and/or offices, in outside sites (e.g., restaurants), with a few taking place by telephone. I sat in on treatment sessions (in the case of one practitioner, once a week for close to two years). I also interviewed nine non-practitioners who were in some way involved with the promotion of Chinese healing modalities in the Boston area. These included academics, store managers, and public officials (men: two Chinese American, six European American; women: one European American).
- iii. I refer to all individuals of Chinese descent who are now citizens of the United States as "Chinese Americans."
 - iv. Two other types of training are offered. The first is a technical-level program providing two to three years of training to students out of middle school and generally sending its graduates to work in rural areas. A second program—a kind of intermediate level—also runs for two to three years, accepts students out of high school who might otherwise not have the opportunity to go to college, and is taught through the regular TCM. These students usually return to their home towns to work in local hospitals and clinics (Ergil 1993).
 - v. The school also offers additional training in selected versions of Japanese acupuncture and is just beginning to explore aspects of Tibetan practice.
 - vi. Most practitioners in the Boston area work out of private offices or in small-group practices. If they work in the latter, then they may either be part of a collective of acupuncturists or share office space with other holistic practitioners like muscular therapists, massage therapists, homeopaths, naturopaths, nutritionists and, occasionally, biomedical physicians. If they are on the faculty of NESAs, they may give treatments through the school's clinic while also supervising students who offer treatments at a lower fee in order to gain experience. Alternative health centers have emerged on the local scene, offering additional working outlets for practitioners. Some practitioners volunteer in the AIDS Care Project, a clinic opened in 1990 by faculty and students from the New England School of Acupuncture. Acupuncture has gradually entered the hospital repertoire in Boston, albeit in limited ways. A few practitioners collaborate with physicians specializing in sports medicine. More important, a number of hospitals now have acupuncturists in their pain clinics. Acupuncture is also used in the drug detox program at Boston Medical Center, and an acupuncture clinic opened in 1997 at the South Cove Community Health Center's Family Life Center.
 - vii. In 1983 acupuncture needles were declared by the FDA to be "experimental," a status not revoked until 1996.
 - viii. Cheng Dan'an, as a medical reformer in Mainland China, strategically integrated aspects of biomedical approaches to anatomy into how Chinese medicine represents the body, and he contributed to restoring the credibility of acupuncture (see Andrews 1994).
 - ix. For a discussion of the changing curriculum at NESAs, see Tu (1999).
 - x. The passage of a direct electrical current into the body, widely used in China, to be used in this case on cultured cells (Editors, 1994)
 - xi. This figure is provided by <http://www.acupuncturetoday.com/List/info/aculocatorzip/massachusetts.html>, (downloaded 3 October 2002). In contrast, the other states of New England have fewer licensed practitioners: Maine (76), New Hampshire (48), Vermont (91), Connecticut (138), and Rhode Island (38). Midwestern states vary, with Minnesota listing 318 acupuncturists in contrast to Oklahoma's 43, while, in the Southwest, New Mexico has 333 and Texas 460.

On the other hand, some other states that also have a long-standing tradition of acupuncture schools far outdistance Massachusetts (e.g., New York [859] and California [5,639]). As of October 2002, there were 34 accredited programs in the United States and eight candidate programs (<http://www.medicalacupuncture.org/cme/cme/acaom.html>, downloaded 3 October 2002).

- xii. An ancient practice from China involving the harmonious alignment of buildings, graves, furniture, and landscape elements, using a special compass (*luopan*) to discern the most auspicious patterning of *qi*

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