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Wahlberg, Ayo

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# **A quackery with a difference – new medical pluralism and the problem of ‘dangerous practitioners’ in the United Kingdom**

Ayo Wahlberg, BIOS Centre, London School of Economics and Political Science

## **Abstract**

The figure of the ‘miracle cure’-peddling quack pretending spectacular properties for worthless tonics is iconic. From their 19<sup>th</sup> century traveling wagon shows to their 21<sup>st</sup> century internet spam scams, hucksters and cranks have been consistently targeted by health authorities as a danger to public health. Yet, in this paper, I argue that this is only one form that the *problem* of ‘quackery’ has taken in the past two centuries or so in the United Kingdom. Just as Roy Porter showed how the mid-19<sup>th</sup> century professionalization of medicine gave rise to a ‘quackery with a difference’ as a whole range of new medical movements – homoeopathy, hydropathy, medical botany, mesmerism – actively denounced allopathic or modern medicine, I will suggest that the late 20<sup>th</sup> century birth of ‘complementary and alternative medicine’ (CAM) has resulted in yet another transformation in quackery. By examining the ways in which regulatory authorities in the UK have come to address what is invariably described as a “growing interest in CAM”, I will show how the problem of quackery today is increasingly located in an ethical field of practitioner competency, qualifications, conduct, responsibility and personal professional development, almost (but not quite) regardless of the form of therapy in question.

## **Key words**

United Kingdom, quackery, new medical pluralism, complementary and alternative medicine, medical ethics

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## **Address**

BIOS Centre, London School of Economics, Houghton Street, London WC2A 2AE, UK

Tel: +44 (0)20 7107 5201, fax: +44 (0)20 7955 7405, e-mail: a.j.wahlberg@lse.ac.uk

## **Introduction**

It is surely the quack who stands as one of the most controversial, problematic, if not colorful figures of modern medical history. Whether peddling miracle tonics throughout the countryside, coaxing desperate patients into improvised backstreet surgeries or condemning medical establishments for their theoretical and therapeutic fallacies, the 'quack' has been a consistent target of highly contested public protection strategies in the past few centuries in the United Kingdom. Campaigns against the quacks, charlatans, mountebanks, cranks, and hucksters of medicine in Britain go back at least as far as the 16<sup>th</sup> century when the kingdom's first Parliament Act regulating the practice of medicine was passed in 1512, not least as a response to the "great multitude of... common artificers, smiths, weavers and women, [that] boldly and accustomably took upon them great cures, to the high displeasure of God, great infamy of the faculty and the grievous hurt, damage and destruction of many of the King's liege people" (cited in Griggs, 1997: 56-57). And the 18<sup>th</sup> to early-19<sup>th</sup> century period is sometimes referred to as the 'golden age of quackery', a time where worthless treatments and charlatan practitioners were seen to be "destroying the very vitals of the nation" (Porter, 1989: 222). More recently, the House of Lords Select Committee on Science and Technology has called for measures to "ensure that the public are protected from incompetent and dangerous practitioners" as interest in complementary and alternative medicine (CAM) increases (House of Lords, 2000: 6.1). Common to these controversies has been a suggestion to ban, exclude or limit the medical practice of those deemed to be damaging rather than improving the health of individuals as a measure of public protection.

In social studies of medicine, it has been common to account for such dividing practices in the context of professionalization, where professions can be seen as groups or bodies that restrict access to certain titles and market opportunities by claiming ownership of an esoteric expertise which is vital to the public interest – e.g. medicine – or as closed bodies that collectively decide on the credentials that give individuals access to protected titles and opportunities as a way to protect its self-interests. Some of the first social studies of medical practice identified exclusion, subordination and limitation as strategies pursued by state-sanctioned biomedical professions to protect their practice and/or to protect the public; often to the detriment of so-called 'fringe', 'marginal' or 'quack' practitioners (Freidson, 1970; Saks, 1995; Starr, 1982; Wallis & Morley, 1976; Willis, 1983). With growing sociological interest in CAM, more recent empirical studies have taken up these themes when accounting for the different ways in which alternative practitioners have embarked on professionalizing strategies of their own as they seek to improve their legal standing and legitimacy (Clarke, Doel, & Segrott, 2004; Kelner, Wellman, Boon, & Welsh, 2004; Quah, 2003; Saks, 2003). Such studies have shown how professionalization among CAM practitioners can be competitive as various fragmented associations vie to become 'representative' of, for example, homeopaths, herbalists or acupuncturists. They have also demonstrated a certain

convergence in the ways in which CAM professional organizations have modeled themselves compared to the biomedical profession.

In this paper, rather than approaching such developments in the United Kingdom (UK) in terms of professionalization, I will be analyzing complementary and alternative medicine as a field of problematization (Foucault, 1977; 1991). As such, I will not be examining what motives and interests are at stake in ongoing efforts to regulate the practice of CAM, instead I will analyze how the contemporary practice of CAM in the UK is constituted as a problem as well as what measures have been/are being put into operation to address this. In particular, I will be arguing that the relatively recent birth of CAM is once again transforming the ways in which the public is to be protected from 'quackery' in the UK. To do so, I will show how a "growing interest" in the practice and use of CAM therapies (BMA, 1986) and the subsequent rise of a "new medical pluralism" (Cant & Sharma, 1999) are not so much leading to a diminishing of dividing practices as to an *internalization of dividing practices*. As various CAM therapies come to be mainstreamed into national health delivery, their practitioners are increasingly being called upon to help the public distinguish between the competent and the incompetent within a plurality of different forms of medicine. Consequently, just as Porter (1989) argued that the mid to late-19<sup>th</sup> century consolidation of modern medicine in Britain resulted in a 'quackery with a difference', I will argue that we are once again in the midst of such a transformation.

What follows, then, is an analysis of how the problem of quackery – damaging rather than beneficial medical practice – has come to be posed and addressed today in the UK, how distinctions between "registered" and "dangerous practitioners" have come to be made as well as what effects these dividing practices are having. As such, I will be covering a wide range of legislation, policy documents, CAM practitioner association proposals, parliamentary committee investigations, as well as expert reports. I will also point to similar initiatives in other countries of the world to highlight the global form that medical regulation takes today. Drawing on a number of social historians of medicine, I will start by showing how the problem of quackery was transformed in the mid-19<sup>th</sup> century. I will then go on to show how, following the birth of CAM in the closing decades of the 20<sup>th</sup> century, this problem is once again in the process of being transformed in the UK.

### **Quacks and quackery in the golden age of biomedicine**

As a number of scholars have demonstrated, from the 19<sup>th</sup> century onwards nation after nation has pursued a strategy of 'medical professionalization' in the name of protecting their citizens from the life-threatening dangers that unqualified practitioners and untested medicines pose (Berlant, 1975; McClelland, 1991; Peterson, 1978; Ramsey, 1988; Schepers & Hermans, 1999; Willis, 1983). The

new Academies, Associations, Colleges and Councils of Medicine that appeared throughout Europe and America during the 19<sup>th</sup> century were legally presented as important parts of an urgent quest to sort the qualified from the unqualified in an otherwise dangerously liberal and lucrative market for nostrums, herbal remedies and treatments – “it is expedient that Persons requiring Medical Aid should be enabled to distinguish qualified from unqualified Practitioners” (Great Britain. Parliament, 1858). From this moment onwards, it is argued, state-sanctioned biomedical monopolies ultimately separated biomedically competent practitioners from especially non-biomedical practitioners, heralding a ‘golden age of biomedicine’ (Cooter, 1988; Inglis, 1964; Johnston, 2004; Saks, 1995; Starr, 1982; Wallis & Morley, 1976; Willis, 1983).

Interestingly, around the same time that such state-sanctioned medical professions were consolidating themselves, a number of medical movements ranging from homoeopathy, acupuncture, hydropathy, medical botany, osteopathy to mesmerism also began taking off throughout Britain, Europe and America (see Brown, 1982; Cooter, 1988; Darnton, 1968; Porter, 1989; Saks, 1992). Common to the proponents of these movements, and what made them different from the hucksters and snake-oil vendors, was a reasoned conviction that allopathic medicine, with its ‘poisonous’ drugs and ‘mechanistic’ view of the individual, had got it all wrong. Importantly, it was not scientific medicine as such that was being challenged by these medical movements, rather it was the ‘flawed’ conclusions of established medicine about the nature and cause of health and disease.

Nevertheless and notwithstanding some initial success, many of the charismatic leaders and practitioners of these medical movements were eventually pushed to the fringes and margins of medicine, often condemned as the new ‘quacks’ of a biomedical age (see Inglis, 1964; Saks, 1992; Wallis & Morley, 1976). Indeed, the medical profession was so successful at defending the boundaries of its competencies, that the period spanning the late 19<sup>th</sup> to mid-20<sup>th</sup> centuries is often referred to as the “dark ages” of such modes of therapy as homoeopathy, acupuncture and herbalism in the UK, with numbers of both users and practitioners falling into steady decline, albeit without ever completely disappearing (Griggs, 1997; Inglis, 1964; Saks, 1995). Numerous studies have shown how these (and other) ‘fringe medicines’ and their practitioners were systematically shunned and brought into disrepute by the medical journals of the day, kept off the curricula of medical schools, denied coverage by the emergent public and private health insurance schemes, and refused the privilege of becoming registered practitioners. As the argument goes, the medical profession was able to keep practitioners of ‘marginal medicine’ at bay by actively pursuing strategies of subordination, limitation or exclusion, while also ostracizing the medical heretics amongst their own ranks who dared to stray from orthodoxy (see Brown, 1985; Cooter, 1988; Dew, 2003; Inglis, 1964; Saks, 1995; Salmon, 1984; Wallis & Morley, 1976; Willis, 1983; Wrobel, 1987).

While the term 'quackery' has its origins in the therapeutic plurality of early modern Britain where sellers of patent medicines were often accused of quacking or exaggerating the curative properties of their wares, in the 'golden age of biomedicine' contestations and controversies often took place in an epistemological field of competing theories and concepts of health and disease. This was 'a quackery with a difference' (Porter, 1989: 232), and it is with this understanding of it that we should explain the eventual denial of a Medical Herbalists Bill (which would have given them statutory recognition as a medical profession on par with biomedical doctors) by the Ministry of Health in 1923 on the grounds that it is "doubtful whether a trained herbalist is any less dangerous than an untrained one" (Chief Medical Officer cited in Larkin, 1992: 117). In a similar vein, Saks (1986) has shown how the 'esoteric' theories of Chinese medicine were often highlighted in campaigns to dismiss acupuncture in the early part of the 20<sup>th</sup> century, and Larkin has shown how the theories of osteopaths came to be attacked in the *British Medical Journal* as "far-fetched and fanciful, and, when applied to grave diseases such as typhoid fever and diphtheria, as decidedly dangerous" (1992: 116).

In effect, the battleground of good vs. bad medicine was broadened from a mainly commercial field of patent medicines and miracle cure products to include an epistemological field of competing theories about the underlying causes of illness and disease. In this sense 'quackery' came to denote the actions of not just hucksters and cranks, but also a whole new category of 'pseudo-practitioners', ranging from registered heretics and deviants within the medical profession to marginal, fringe or quasi-practitioners of non-biomedical therapies, all of whom were considered dangerous not so much (or at least not only) because of the products they peddled but rather because of their heretic or unorthodox beliefs. Regarded as ineffectual at best and lethal at worst by state-sanctioned medical associations, members of the public were to be shielded from non-biomedical forms of therapy as a matter of protecting their health.

### **The birth of CAM**

Yet, this 'golden age of biomedicine' would not last indefinitely. After nearly a century of dominance, state-sanctioned biomedical professions found themselves increasingly under fire from both within and without by a motley group of professionals, academics and grassroots activists that amounted to what Saks (2003) has aptly described as an emergent medical counter-culture. Indeed, by the late 1970s, questions were (yet again) being asked in many industrialized countries as to how many people were actually seeking medical help outside authorized and established sources.

In 1981, the Commission on Alternative Systems of Medicine that Dutch State Secretary for Health and Environmental Protection Jo Hendriks had put together in 1977 famously concluded that "the

consensus of public opinion is no longer behind the [biomedical] monopoly, and the law is broken a thousand times a day as sick and disabled people seek the help of people, who are not legally authorized to provide it" (The Netherlands. Ministry of Health., 1981: 1). Since then, we have seen somewhat of a barrage of national hearings, public inquiries and committee investigations into the growing use of CAM throughout the industrialized world. These include: Denmark's State Procurement Agency's "Committee investigating natural products and unauthorized healing therapies" which reported in 1983; the Swedish Minister of Health's Alternative Medicine Committee formed in 1984; the Australian Parliament Social Development Committee's "Inquiry into alternative medicine and the health food industry" reporting in 1986; the French Ministry of Social Affairs and Solidarity's expert group to evaluate "Médecines différentes" formed in 1986; the United States Congressional Subcommittee on Departments of Labor, Health and Human Services, Education, and Related Agencies' hearings on "Alternative medicine" in 1993; the Norwegian Ministry of Health and Social Affairs' "Public Assessment of Alternative medicine" from 1998; the USA's White House Commission on Complementary and Alternative Medicine reporting in 2002; and more recently, a Ministerial Advisory Committee's report on "Complementary and Alternative Health Care in New Zealand" for the Minister of Health in 2004.

And so it was in the closing decades of the 20<sup>th</sup> century that a whole range of what (for just over a century) had been considered 'fringe', 'marginal' or even 'quack' therapies in the industrialized world (see Bynum & Porter, 1987; Inglis, 1964; Ruggie, 2004; Wallis & Morley, 1976) became known as 'alternative', 'natural', and later, 'complementary'. In the UK, the British Medical Association (BMA) had, in a 1986 report, tried to shrug off "growing interest in complementary medicine" as nothing more than a "passing fashion", citing their duty to warn patients "that consultation with practitioners of some alternative therapies may be attended by the risk of great harm" (BMA, 1986: 1, 73-4). Not too surprisingly, however, instead of stifling debate, this report would end up as the catalyst for a series of debates, legislative proposals and regulatory initiatives that have paved the way for some kind of official sanctioning of a 'new medical pluralism' in the UK. Since then, osteopaths and chiropractors have achieved statutory recognition through parliamentary Acts in 1993 and 1994 respectively, and more recently a similar route has been embarked on by acupuncturists and herbalists. The numerous and fragmented organizations representing practitioners of other therapies, such as homoeopathy, aromatherapy and naturopathy, have also begun exploring ways of uniting as single occupations. As a provisional culmination of this move towards mainstreaming CAM in the UK, the House of Lords Select Committee on Science and Technology published their report on "Complementary and Alternative Medicine" in November 2000, making a range of recommendations which are currently under debate (House of Lords, 2000).

### **Hierarchizing the CAM field**

How then should we understand the past twenty years' worth of efforts to unify, regulate and thereby mobilize some of the many forms of therapy that have come to be classed as CAM in the UK? Most importantly, these regulatory initiatives have been justified in terms of a concern for public protection – “the widespread and increasing use of CAM... raises significant issues of public health policy such as whether good structures of regulation to protect the public are in place” (House of Lords, 2000: 1). As a result, health authorities have focused their efforts on building up a system of contained (self-)regulation of CAM practice. And while the officially-endorsed moves towards statutory and voluntary self-regulation underscore the fact that far from all non-biomedical practitioners are considered a public health hazard today (as they were to a much larger extent in the past), it is also clear that one of the primary, explicitly stated goals of (self-)regulation is to “ensure that the public are protected from incompetent and dangerous practitioners... whose continuing practice presents an unacceptable risk” (House of Lords, 2000: 5.1, 6.1). In somewhat of a change in tactics, the BMA had already conceded in a 1993 report on new approaches to good practice in CAM that “it is not the place of the medical profession to proscribe the legitimate activities of consumers in health care” (BMA, 1993: 2). That did not, however, mean that growing use of CAM could be ignored as “doctors [do] have a duty to... safeguard the public health and, to this end, it is important that patients are protected against unskilled or unscrupulous practitioners of health care” (ibid.).

The novelty in this change of heart is of course not the suggestion that there are dangerous, incompetent, unskilled and unscrupulous CAM practitioners who pose a threat to the public, but rather it is the acceptance that there is in fact such a thing as a competent, skilled and responsible CAM practitioner. As a result, and echoing the preamble to the 1858 Medical Act, the House of Lords Select Committee argued that “the effective regulation of [CAM]... allows the public to understand where to look in order to get safe treatment from well-trained practitioners” (House of Lords, 2000: 5.1), a regulatory function that until very recently had been pretty much reserved for the biomedical profession in the UK. And so it is precisely here that we can see the outline of a transformed public protection rationality: rather than directly advise against using ‘fringe medicines’ or discourage their practitioners from practicing, protecting the public today entails helping the public to know where to look (consumer awareness) on the one hand, and ensuring that CAM practitioners are well-trained and qualified on the other (practitioner competence). Gone is the provocative language of ‘quackery’ and ‘miracle cures’, yet only, as we will see, to be replaced by a new normativity of ‘responsible practice’, ‘appropriate use’ and ‘safe and effective therapies’.

Strategies of consumer awareness-raising in the UK have to date employed two specific routes. Firstly, a comprehensive mapping out of just what kinds of different therapies are on offer to CAM consumers, and secondly, a taxonomizing and ranking of these therapies according to criteria of

health value/danger. Probably the most famous of such hierarchizations can be found in the Select Committee report from 2000, but more recently a consumer guide from the Prince of Wales's Foundation for Integrated Health (PWFH) has also grouped CAM therapies under headings of 'statutorily regulated', 'proposals made for statutory regulation' and 'other', and in a reader's guide the national daily newspaper *The Times* has star-rated a range of therapies (see Table 1). It is important to understand what the key principle of taxonomy has been in each case.

According to the House of Lords Select Committee, an important means of helping the public know where to look is first of all to rank CAM therapies according to their "scientifically established" evidence base. The Select Committee's ranking of therapies into three separate groups was undoubtedly the most contentious element of their report, sparking wide debate as to what criteria were appropriate for such an exercise. For the Committee, the first group of "principal disciplines" were distinguished by "scientifically established efficacy in the treatment of a limited number of ailments". The second group consisted of "complementary therapies" which "give help and comfort to many patients when used in a complementary sense to support conventional medical care even though most of them lack a firm scientific basis". And finally, the last group of "alternative disciplines" were described as "indifferent to the scientific principles of conventional medicine" and "lack[ing] a credible evidence base". While consumers are not explicitly advised against using Group 3 therapies, the Select Committee does argue that these therapies "cannot be supported unless and until convincing research evidence of efficacy based upon the results of well designed trials can be produced" (House of Lords, 2000: 2.1-2.11). Similarly, *The Times'* star-rating of a range of therapies was based on both available "research evidence" and "research quantity", and readers are advised to stay clear of a few therapies which are not seen to merit any stars at all (Ahuja, 2006).

On the other hand, the main principle of taxonomy used by the PWFH in their threefold grouping of the "most widely used" therapies was not so much a therapy's evidence base, but rather the extent to which they protect consumers from "untrained or insufficiently trained" practitioners (PWFH, 2005: 7). For the Foundation, regulation is the key to ensuring safe and responsible practice and while "osteopaths and chiropractors are regulated by law, like doctors and nurses... the other complementary healthcare professions are at different stages of developing voluntary systems of regulation" (PWFH, 2005: 13). In other words, the three groupings of therapies used in their report indicate the respective "stages" of their systems of regulation. The aim of the Foundation's guide is to help consumers "find a properly trained and qualified practitioner of that therapy" and in the absence of effective regulatory systems (e.g. for therapies classed as "Other") to suggest "questions to ask a practitioner before going for treatment" (PWFH, 2005: 7, 16).

**Table 1: CAM hierarchies**

House of Lords Select Committee	PW Foundation for Integrated Health	<i>The Times</i>
<b>Group 1: Principal disciplines</b> Acupuncture, Chiropractic, Herbal medicine, Homoeopathy, Osteopathy	<b>Statutorily regulated</b> Chiropractic, Osteopathy	<b>4 stars</b> Western herbal medicine, Acupuncture
<b>Group 2: Complementary Therapies</b> Alexander Technique, Aromatherapy, Bach remedies, Body work therapies (including massage), Counselling stress therapy, Hypnotherapy, Meditation, Reflexology, Shiatsu, Healing, Maharishi Ayurvedic Medicine, Nutritional medicine, Yoga	<b>Proposals made for statutory regulation</b> Acupuncture, Herbal medicine	<b>3 stars</b> Chinese Herbal Medicine
		<b>2 stars</b> Chiropractic, Osteopathy
<b>Group 3: Alternative Disciplines</b> <i>3a Long-established and traditional systems of healthcare:</i> Anthroposophy, Ayurvedic Medicine, Chinese Herbal Medicine, Eastern Medicine, Naturopathy, Traditional Chinese medicine  <i>3b Other alternative disciplines:</i> Crystal therapy, Dowsing, Iridology, Kinesiology, Radionics	<b>Other therapies</b> Aromatherapy, Craniosacral therapy, Healing, Homoeopathy, Hypnotherapy, Massage therapy, Naturopathy, Nutritional therapy, Reflexology, Reiki, Shiatsu, Yoga therapy	<b>1 star</b> Homoeopathy, Aromatherapy, Reflexology
		<b>“well, just don’t go there”</b> Bi-aura therapy, Radionics, Holographic repatterning, Watsu

(Ahuja, 2006; House of Lords, 2000; PWFH, 2005)

The point to be made about the Select Committee’s, Foundation’s and *Times*’ respective hierarchizations of CAM therapies is that they demonstrate how dividing practices are in the first instance being internalized into a differentiated CAM field in general. It is evident that the blocs often associated with the golden age of biomedicine (i.e. a biomedical ‘us’ vs. a non-biomedical ‘them’) are in the process of being nuanced to reflect medical pluralism in the UK today. And as I have suggested, this nuancing has been made possible in the first instance by mapping out, evaluating and taxonomizing the different forms of therapy on offer to consumers as a means of helping them know where to look. Consumer vigilance is encouraged all the more if a therapy’s regulatory mechanisms are seen as fragmented or if a ‘credible evidence base’ is lacking –“you should really have more information before you make a decision about which complementary therapy to use” (PWFH, 2005: 9).

### **Disciplining CAM practice**

As already noted, further to consumer awareness programs, mobilizing and mainstreaming CAM in the UK has also entailed ensuring the safe and responsible practice of CAM. And again it is possible to identify two key objectives in these latter efforts. The first has been to actively encourage the unification and organization of practitioners of particular therapies into accountable,

transparent and representative Associations. Even though practicing homoeopaths and herbalists, for example, have had a long history of self-organization dating back to the 19<sup>th</sup> century, underscoring their premise that good CAM regulation helps the public know where to look, the House of Lords Select Committee argued that “the public cannot have full confidence in those therapies where there is considerable professional fragmentation” and consequently recommended that “in order to protect the public, professions with more than one regulatory body make a concerted effort to bring their various bodies together and to develop a clear professional structure” (House of Lords, 2000: 5.12).

It is without doubt the case that both historically and contemporarily, many forms of CAM in the UK have been characterized by such fragmentation, with a wide array of organizations representing not just different CAM therapies, but also different groups of practitioners within each individual therapy. As already noted, osteopaths (1993) and chiropractors (1994) were the first to be given statutory recognition through Parliamentary Acts in return for a commitment to self-regulate their own practitioners by establishing a single unified register of qualified practitioners as well as ensuring strict education and curriculum criteria. Herbal medicine and acupuncture are currently next in line for statutory recognition since, as argued in the Select Committee report, the practice of “both acupuncture and herbal medicine do carry inherent risk, beyond the extrinsic risk that all CAMs pose, which is the risk of omission of conventional medical treatment” (House of Lords, 2000: 5.54). In 2001, a Herbal Medicine Regulatory Working Group (HMRWG) was formed as a joint initiative of the Department of Health, the PWFH and the European Herbal Practitioners Association and with representation from no fewer than 11 herbal medicine organizations, representing some 1,500 practitioners. The Working Group reported in 2003, making a range of proposals for the statutory regulation of the herbal medicine profession as a whole. Similarly, an Acupuncture Regulatory Working Group was also formed in 2001 with representation from 4 acupuncture associations. And finally, practitioners of other therapies have also been encouraged to join forces under single umbrella organizations, although at this stage not with an imminent prospect of statutory recognition.

The second, and in many ways most important priority in efforts to ensure the safe and responsible practice of CAM has been to specifically target the qualifications and competencies of its practitioners. Indeed, if there is one feature one were asked to highlight from the ongoing transformations in quackery that I am accounting for in this paper, it would have to be the focus on practitioner qualifications and conduct. For if the public is to be safeguarded and their health promoted, then it is clear that the public must be protected from what in recent CAM regulatory initiatives have variously been called the “incompetent and dangerous practitioners”, the “unskilled or unscrupulous practitioners” and the “unqualified individuals” of these therapies (BMA, 1993; European Parliament, 1997; House of Lords, 2000). To tackle this pressing objective, which it must

be stressed has in no way been unique to CAM but rather has with equal urgency obligated biomedical practitioners (see below), a number of practical initiatives have been launched as a means to install what the HMRWG has called “procedures to protect patients and the public from individuals it deems unfit to practise” (HMRWG, 2003: 19). It is true that, for example, the largest herbal practitioner organization in the UK, the National Institute of Medical Herbalists (NIMH) has since the 19<sup>th</sup> century explicitly worked to “repress malpractices” (NIMH, 1979), yet, as we saw earlier this was for the most part without state sanctioning. Moreover, in 1991, with numbers of actively practicing herbalists on the rebound, updated Codes of Ethics and Practice as well as Disciplinary Procedures were adopted by the NIMH setting out the consequences of “Dishonourable Conduct and Professional and Ethical Misconduct” for members.

Based on its own experiences, the BMA has argued that five important areas should be covered by such codes:

To provide a code of conduct, a disciplinary procedure, and a complaints procedure; to provide minimum standards of training and to supervise training courses and accreditation; to understand and advertise areas of competence, including limits of competence within each therapy; to keep an up to date register of qualified practitioners; and to provide and publicize information on CAM.  
(cited in House of Lords, 2000: 5.14)

At stake is a kind of normalization or disciplining of practice through the setting of standards and qualifications as well as procedures for addressing cases where registered practitioners deviate from codes of conduct. It is not only a question of ensuring minimum competency through the setting of criteria for those wishing to register as qualified practitioners, but also of insisting on an ongoing engagement with what is increasingly referred to as ‘continuing professional development’ (see Clarke, Doel, & Segrott, 2004). As argued by the World Health Organization (WHO), it is about “improving their skills in... prescribing and utilizing medicines in safe and consistent ways” as well as “[e]xpanding the knowledge and skills of [CAM] practitioners so they can assume more responsible roles in primary health care programs” (WHO, 1995: 47, 9).

As already said, this drive to discipline practice has in no way been limited to the CAM field. The biomedical profession in the UK has itself seen a considerable rise in cases of “(un)fitness to practice” and “serious professional misconduct” in recent decades (see Bradby, Gabe, & Bury, 1995; Stacey, 1992). Following high-profile malpractice cases like those of Harold Shipman and Beverley Allitt, the Department of Health has recently submitted a proposal to Parliament which recommends usurping the General Medical Council’s “power to adjudicate on fitness-to-practice cases” and argues that as a matter of “Trust, Assurance and Safety” it is necessary for the government to “ensure that all the statutorily regulated health professions have in place arrangements for the revalidation of their professional registration through which they can

periodically demonstrate their continued fitness to practice” (BBC News Online, 2007; Department of Health, 2007: 6).

For CAM practitioners, professional procedures become a kind of (self-)policing mechanism, as they stipulate the minimum qualifications, kinds of conduct, professional training requirements and annual fees that are demanded of them and fellow practitioners if they are to be authorized as registered practitioners. In return, they are given access to various kinds of support in their continuing professional development, the right to use a certain protected titles such as ‘herbalist’ or ‘chiropractor’, as well as guidelines on how to act in challenging clinical situations (e.g. when to refer a patient to a biomedical doctor). But it is also these self-policing mechanisms that have proven contentious as they inevitably generate grounds for an entire range of exclusionary practices. At risk of exclusion in the UK are all those practitioners who, for whatever reasons, either cannot live up to the requirements of their Associations or, once registered, breach codes of conduct. The prospects for this outsider group are that while they will share a common lack of access to a protected title and register, their reasons for being excluded can be as varied as not being able to afford Association membership dues and post-registration exclusion because of “unacceptable professional conduct” (HMRWG, 2003: 121).

What members of the public as well as health authorities get from such procedures of (self-)policing is what might be thought of as a whole range of practices of assurance from the CAM practitioners they consult or sanction. They are assurances of accountability, competency and ethical conduct, with all the debates over just what constitutes ‘safety’, ‘quality’ and ‘efficacy’ that have unavoidably followed. As summarized in the PWFH’s consumer guide on CAM, these practices of assurance serve to provide the public with clear information on “how to find a properly qualified and competent complementary practitioner [and] what to do if you are unhappy with treatment” (PWFH, 2005: 7).

### **Conclusion: a quackery with a difference**

The mobilization of CAM in the UK continues to gather pace today. This, I have argued, is markedly at odds with early 20<sup>th</sup> century strategies of marginalization, subordination and exclusion, which ironically enough were also justified as concrete means to protect and promote the public’s health. It is the form of the problem that has changed. In no way unique to the UK, this change in tactics has perhaps most succinctly been summarized by the White House Commission on Complementary and Alternative Medicine, who in 2002 argued that:

the question is not, ‘Should [people] be using complementary and alternative medicine modalities?’ as many – perhaps most – already are doing so... Until recently, the primary

response of Federal, state, and local health care regulatory agencies to this phenomenon was to restrict access to and delivery of Complementary and Alternative Medicine services to protect the public from unproven and potentially dangerous treatments. Since the early 1990s, however, scientific evidence has begun to emerge suggesting that some CAM approaches and products, *when used appropriately*, can be beneficial for treating illness and promoting health. (United States. White House Commission on Complementary and Alternative Medicine, 2002, my emphasis)

To this summary we can now also add 'when practiced responsibly'. The shift is conspicuous. Rather than ban or restrict access to CAM practitioners (as happened in the UK and many other countries in the early 20<sup>th</sup> century), the aim of contemporary efforts to regulate CAM has been recast into what might be termed a normalization of its practice and use. And in the process, it seems that we are once again witnessing the emergence of a quackery with a difference. Whereas in the 18<sup>th</sup> and 19<sup>th</sup> centuries a large part of the battles against quackery were fought out in a commercial field of miracle cures and patent medicines and in the late 19<sup>th</sup> and early 20<sup>th</sup> centuries this battleground expanded into an epistemological field of competing theories of health and illness, in the UK today, the battlefield it seems is once again shifting, this time into an ethical field of practitioner competency, qualifications, conduct, responsibility and personal professional development, almost (but not quite) regardless of the therapy in question. This is not to say that the fraudulent sale of miracle cures has ceased or that the exaggeration of practitioner abilities has entirely disappeared. Neither is it to suggest that all forms of CAM have been welcomed 'into the fold'. We saw how those forms of therapy found in group 3 of the House of Lords Select Committee's CAM hierarchy, such as crystallography or radionics, continue to be excluded from state-sanctioned regulatory initiatives on the grounds of 'backward' or 'unverified' healing practices. Indeed, the active hierarchization of CAM therapies has been an important feature of the internalization of dividing practices that I have described in this paper.

Nevertheless, to the extent that CAM therapies are being mobilized in the UK, what I have argued is that this has been made possible by a normalization and disciplining of its practice. While a practitioner may in the past have been a quack for the mere fact of practicing or even associating with a non-biomedical therapy, today's "dangerous practitioner" is more one who is deemed to be practicing medicine (whether complementary, alternative or modern) irresponsibly, incompetently or unscrupulously to the detriment of the public. Yet, if this transformation has opened up a space for a number of CAM therapies in British national health delivery, it has also unavoidably produced a number of dividing practices *within* these various forms of therapy as they attempt to unify under single registers.

Accounting for such dividing practices in terms of professionalization, as has been common to date, can undoubtedly tell us a great deal about the motivations and interests of certain groups as

they vie for status, authority, legitimacy and exclusivity. Yet, what such a professions approach does not help us to identify is how transforming rationalities and practices of public protection contribute to changing forms of the problem of quackery and vice versa. What I have shown in this paper is that while banning, excluding or limiting the medical practice of those deemed to be damaging rather than improving the public's health has been a consistent strategy of public protection since at least the 19<sup>th</sup> century, the way in which the problem of 'dangerous practitioners' has come to be posed has certainly changed.

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**Table 1: CAM hierarchies**

House of Lords Select Committee	PW Foundation for Integrated Health	<i>The Times</i>
<b>Group 1: Principal disciplines</b> Acupuncture, Chiropractic, Herbal medicine, Homoeopathy, Osteopathy	<b>Statutorily regulated</b> Chiropractic, Osteopathy	<b>4 stars</b> Western herbal medicine, Acupuncture
<b>Group 2: Complementary Therapies</b> Alexander Technique, Aromatherapy, Bach remedies, Body work therapies (including massage), Counselling stress therapy, Hypnotherapy, Meditation, Reflexology, Shiatsu, Healing, Maharishi Ayurvedic Medicine, Nutritional medicine, Yoga	<b>Proposals made for statutory regulation</b> Acupuncture, Herbal medicine	<b>3 stars</b> Chinese Herbal Medicine
<b>Group 3: Alternative Disciplines</b> <i>3a Long-established and traditional systems of healthcare:</i> Anthroposophy, Ayurvedic Medicine, Chinese Herbal Medicine, Eastern Medicine, Naturopathy, Traditional Chinese medicine  <i>3b Other alternative disciplines:</i> Crystal therapy, Dowsing, Iridology, Kinesiology, Radionics	<b>Other therapies</b> Aromatherapy, Craniosacral therapy, Healing, Homoeopathy, Hypnotherapy, Massage therapy, Naturopathy, Nutritional therapy, Reflexology, Reiki, Shiatsu, Yoga therapy	<b>1 star</b> Homoeopathy, Aromatherapy, Reflexology
		<b>“well, just don’t go there”</b> Bi-aura therapy, Radionics, Holographic repatterning, Watsu

(Ahuja, 2006; House of Lords, 2000; PWFH, 2005)