For more than a decade, Juliana van Olphen-Fehr ran an independent practice as a nurse-midwife delivering babies in women's homes. In the following story, she gives us a sense of what it is like to participate in a home birth:

> *Late in the evening, Mona's contractions started getting quite intense. She paced around the room while we watched. She'd sit on the toilet frequently and Dave [her husband] rubbed her back when she was on the bed.... We tried to encourage Dave to go take a nap but he didn't want to leave Mona for a moment. He finally fell asleep in the bed while it was our turn to rub Mona's back. The night moved into early morning. The clock ticked away. We walked and talked.*
>
> *It's amazing how long it takes a baby to be born. As time passes slowly, labor gives one the opportunity to reflect on the process of birth. Each contraction comes and goes, [as] the uterus gets smaller and smaller [and] the baby is massaged down further and further into the pelvis.... Finally, the uterus, getting more powerful as it decreases in size, pushes the baby out of its first cradle, the pelvis, through the vagina, the passageway to life, into the outside world. The mother, feeling more and more pressure, joins the uterus in its expulsive efforts. She bears down gently and involuntarily at first but then more forcefully and purposefully as the baby approaches birth....*
>
> *Mona's labor built up to the point where she started to feel the urge to bear down. Her cervix was completely dilated and I felt the baby's head low in the vagina. She squatted while she pushed during the contractions and walked during the break between them. She found it most comfortable to lean on the banister in her hallway while she pushed.... Dave was still behind her, supporting her hips. I encouraged her to push while I got under her to monitor the baby's heartbeat.*
>
> *Finally, the head appeared. Dave was behind Mona, sitting on the floor, I was beneath her in the front. Together we had our hands around the baby's head, supporting it as we coaxed her to push the baby out slowly. A beautiful little boy was born into Dave's and my hands. I held the baby as Dave eased Mona back onto his lap. His arms were around her as they both welcomed the baby into their arms. My birth assistant covered all three of them with blankets to keep the baby warm with their body heat. We turned the light low so the baby would open his eyes. In happy exhaustion, we sat back and through tears watched this family fall in love with each other (Van Olphen-Fehr, 1998:111–113).*

Van Olphen-Fehr's story helps us see both why women choose to become homebirth midwives and why health care consumers might choose a nontraditional option like home birth. Since this story took place, however, unaffordable insurance premiums have forced virtually all nurse-midwives to abandon independent practice and to work only under direct physician supervision. This situation illustrates the problems faced by nonmedical health care workers in trying to achieve professional status in a system characterized by **medical dominance**.

In this chapter, we first look at the history of four occupations—nursing, nurse-midwifery, pharmacy, and osteopathy—and show how each struggled to find a niche for itself within mainstream health care. We then consider the history of four occupations that, to a greater or lesser extent, remain outside of mainstream health care—chiropractic, direct-entry midwifery, *curanderismo*, and traditional acupuncture. Chiropractic illustrates how, despite medical dominance, an alternative health care occupation can secure a role for itself by limiting its services to a narrow field, while the other three examples show how occupations can remain marginal to the health care system, unable to successfully combat medical dominance.

MAINSTREAM HEALTH CARE PROVIDERS

Nursing: The Struggle for Professional Status

In everyday conversations, Americans often seem to equate health care workers with doctors. Similarly, although many sociologists have researched doctors, very few have researched nurses. Yet nurses form the true backbone of the health care system, and hospital patients quickly learn that it is nurses who make the experience miserable or bearable and whose presence or absence often matters most. The history of nursing demonstrates how the drive toward professional status, or **professionalization**, can be especially difficult for a "female" occupation.

The Rise of Nursing Before the twentieth century, most people believed that caring came naturally to women and, therefore, that families could always call on any female relative to care for any sick family member (Reverby, 1987). Hospitals, meanwhile, relied for custodial nursing care on the involuntary labor of lower-class women who were either recovering hospital patients or inmates of public **almshouses**. These beginnings in home and hospital created the central dilemma of nursing: Nursing was considered a natural extension of women's character and duty rather than an occupation meriting either respect or rights (Reverby, 1987). Nevertheless, increasingly during the nineteenth century, unmarried and widowed women sought paid work as nurses in both homes and hospitals. Few of them, however, had any training.

The need to formalize nursing training and practice did not become obvious until the Crimean War of the 1850s, when the Englishwoman Florence Nightingale demonstrated that trained nurses could alleviate the horrors of war (Reverby, 1987). The acclaim Nightingale garnered for her war work enabled her subsequently to open new training programs and establish nursing as a respectable occupation.

Like most of her generation, Nightingale believed that men and women had inherently different characters and thus should occupy "separate spheres," playing different roles in society. To Nightingale, women's character, as well as their duty, both enabled and required them to care for others. She thus conceived of caring as nursing's central role. In addition, because her war work had convinced

Harper's Weekly, January 21, 1871 National Library of Medicine

Nurses first won the respect of the American public during the Civil War.

her of the benefits of strict discipline, she created a hierarchical structure in which nurses and nursing students would follow orders from their nursing supervisors. This structure, she hoped, would provide nurses with a power base within women's separate sphere parallel to that of doctors within their sphere. These principles became the foundation of British nursing. A few years later, when the U.S. Civil War made the benefits of professional nurses obvious to Americans, these principles were also adopted by American nursing.

By the early twentieth century, hospital administrators discovered that running a nursing school gave a hospital ready access to cheap labor, and so hospitals across the nation began opening such schools. Within these hospital-based schools, education was secondary to patient care, and many schools had neither paid instructors nor libraries. Students worked on the wards for 10 to 12 hours daily, with work assignments based on hospital needs rather than on educational goals. Formal lectures or training, if any, occurred only after other work was done.

This exploitative training system stemmed directly, if unintentionally, from the Nightingale model and its emphasis on caring and duty. As historian Susan Reverby notes (1987:75), "Since nursing theory emphasized training in discipline, order, and practical skills, the ideological justification explained the abuse of student labor. And because the nursing work force was made up almost entirely of women, altruism, sacrifice, and submission were expected and encouraged."

Those women who, by the beginning of the twentieth century, sought to make nursing a profession by raising educational standards, establishing standards

for licensure or registration, and improving the field's status found their hands tied by the nature of the field (Malka, 2007; Reverby, 1987). According to Reverby, to raise its status, nursing reformers

> had to exalt the womanly character and service ethic of nursing while insisting on the right of nurses to act in their own self-interest, yet not be "unladylike." They had to demand higher wages commensurate with their skills and position, but not appear "commercial." Denouncing the exploitation of nursing students as workers, they had to forge political alliances with hospital physicians and administrators who perpetrated this system of training. While lauding character and sacrifice, they had to measure it with educational criteria in order to formulate registration laws and set admission standards. In doing so, they attacked the background, training, and ideology of the majority of working nurses. Such a series of contradictions were impossible to reconcile (1987: 122).

Political weaknesses also hamstrung nurses' attempts to increase their status. Like other women, few white nurses could vote until 1920, and most nonwhite nurses could not do so until considerably later. Moreover, nurses faced formidable opposition from doctors and hospitals that feared losing control over this cheap workforce. Nevertheless, by the 1920s, most states had adopted licensing laws for nursing schools and nurses. But most laws were weak and poorly enforced, so nurses' status remained somewhat marginal until World War II (Judd, Sitzman, and Davis, 2009; Malka, 2007).

Rising Education and Professional Status Since World War II, nursing leaders have focused on increasing educational requirements for entering nursing as a means of achieving professional status (Judd et al., 2009; Malka, 2007). Beginning in the 1960s, the American Nurses Association promoted the development of two- and four-year college-based nursing programs and lobbied to make college education a requirement for nursing. The new college-based programs quickly proved popular because changing social norms encouraged women to seek a college education in the hopes of improved employment opportunities.

This emphasis on higher education has reinforced nursing's hierarchical structure. At the bottom of the hierarchy are nursing assistants (described in Chapter 10) and **licensed practical nurses (LPNs)**, who have at most about one year of classroom and clinical training and who provide mostly custodial care to patients. Neither nursing assistants nor licensed practical nurses have the autonomy, status, or independent knowledge base that sociologists consider crucial for meeting the definition of a profession, nor is it likely that they will ever do so.

The situation is more complex for **registered nurses (RNs)**, individuals who have received at least two years of nursing training and met national licensure requirements. In past decades, most RNs received their training through hospital-based programs unaffiliated with colleges or universities. These days, most RNs hold associate's degrees in nursing from community colleges, and an increasing number hold bachelor's degrees in nursing from four-year colleges or universities.

Without a doubt, these nurses enjoy more autonomy and status than in the past (Malka, 2007). Many large hospitals now have a Director of Nursing who makes largely independent decisions regarding the nursing staff and whose status is parallel to that of the Director of Medicine. Meanwhile, in many wards, nurses and doctors work together in relatively egalitarian teams; this is especially true in emergency departments, intensive care units, and operating rooms, where quick decisions and good rapport between doctors and nurses are crucial (Carmel, 2006).

Continuing Daily Struggles Despite the increasing autonomy that rising levels of education have brought, asserting professional status remains a daily struggle for many nurses (Gordon, 2005). Doctors continue to determine much of nurses' everyday working conditions: who works when, where, and for how much money. And doctors sometimes include abusive treatment as part of these conditions: Almost all nurses who responded to a 2002 national survey reported either experiencing or witnessing incidents in which doctors screamed at nurses, hit or threw things at nurses, abusively criticized them, or otherwise made it difficult for them to function (Rosenstein, 2002).

Even when doctors don't abuse nurses, they often underscore the status difference between them (Gordon, 2005). Most doctors expect to be referred to by their title—"Dr. Smith"—while referring to nurses by their first names or simply as "my nurse." They rarely read nurses' notes on patients' charts, eat with nurses in hospital cafeterias, include nurses in discussions on hospital rounds, or invite nurses to important meetings about patients. Meanwhile, in what is referred to as the **doctor–nurse game**, experienced nurses are still expected to subtly instruct inexperienced doctors in how to treat patients without revealing the doctors' ignorance to onlookers (Gordon, 2005). For example, an experienced surgical nurse might subtly suggest what the doctor should do by placing certain instruments on the table or by telling the patient step by step what the doctor is about to do. Similarly, nurses often do the work of doctors—prescribing drugs, tests, or physical therapy—when doctors are unavailable, but the doctors often reinforce their own status by telling others that the nurses are simply following the doctors' known preferences. Even when patients' lives are saved by nurses' quick actions, doctors typically receive the credit from patients, administrators, and other doctors (Gordon, 2005).

Changing Gender Roles and Professionalization One important factor that may affect nursing's ability to gain professional status is the changes in gender roles in the broader society. Over the past three decades, as women have gained entry to other fields, intelligent and motivated women increasingly have chosen to enter medicine, pharmacy, or biological research instead of nursing (*New York Times*, 1999). As a result, nursing no longer attracts the type of students it once could have counted on for its future leadership. For the same reason, nursing now attracts fewer white students and middle- or upper-class students. Given existing social prejudices, these changes are likely to reduce the status of nursing even if the quality of students remains constant. Finally, because women now *can* enter medicine, the public sometimes assumes that no intelligent woman would

instead choose to enter nursing, and so underestimates the abilities of those who do enter the field (Gordon, 2005).

Changing gender roles not only have encouraged women to seek careers other than nursing but also have opened nursing to men. Men currently constitute about 6% of employed nurses. Because nursing is so strongly identified with femininity, working as a nurse presents men with a serious conflict between their gender identity and their work identity. Men typically respond to this conflict by stressing the differences between what they do and traditional nursing—deemphasizing nurturing while emphasizing their technical skills, quick thinking, or use of physical strength. As a result, men are disproportionately represented in areas considered "masculine" such as operating rooms and emergency departments and underrepresented in areas such as pediatrics (Snyder and Green, 2008).

As in other occupations, men earn significantly more than similarly experienced women. There is no indication so far that the entry of men into nursing will raise salaries, counteract the loss of academically superior and socially prestigious women students, or raise the status of the field overall.

Structural Changes and Professionalization In contrast to changing gender roles, the impact of structural changes in health care on nurses' lives and professional status is more obvious. Since the 1970s, **corporatization** and the resulting emphasis on cost control have resulted in worse working conditions and decreased job satisfaction for most hospital-based nurses. To save costs, hospitals try to release patients before their insurance coverage ends, leaving only the sickest patients in the hospital. Yet to keep their staffing costs as low as possible, hospitals now hire considerably fewer RNs per patient than they used to (Gordon, 2005). Thus, the typical hospital ward now has fewer nurses but sicker patients than in the past.

Other changes have also worsened nurses' position. First, because RNs can perform more tasks more efficiently than LPNs, hospitals now save money by assigning RNs many of the labor-intensive, menial tasks formerly performed by LPNs. Because RNs remain responsible for many administrative and skilled technical tasks, this shift has both deprofessionalized their daily work and dramatically increased their workload (Aiken, Sochalski, and Anderson, 1996; Brannon, 1996; Gordon, 2005). Second, hospitals increasingly save money by hiring nurses temporarily and without benefits or by moving full-time nurse employees from ward to ward as needed. As a result, nurses have considerably less control than in the past over their schedules, the nature of their work, and who they work with. Third, hospitals have saved costs by shifting services from inpatient wards to less expensive outpatient clinics, where fewer RNs are needed, RN salaries are lower, and their work is less prestigious (Norrish and Rundall, 2001). Finally, nurses are increasingly pressured to work back-to-back shifts and longer hours (often unpaid). Taken together, these factors have resulted in very high dropout rates from nursing careers (Gordon, 2005).

Advanced Practice Nursing and Professional Status Although most nurses continue to struggle for professional status, few would doubt that **advanced practice nurses** have achieved that status. Advanced practice nurses (most of whom are also RNs) hold postgraduate degrees in specialized nursing fields. Most have master's

degrees and work as nurse-anesthesiologists, nurse-practitioners, or the like. A much smaller group holds doctoral degrees in nursing and typically work as researchers or professors. Doctoral-trained nurses now run their own classrooms, laboratories, research journals, research grants, and licensing boards; generate knowledge parallel to that generated by medical doctors; earn high salaries; and enjoy autonomy, status, and public respect similar to that of many other professionals. In recognition of their advanced training, most state governments give all advanced practice nurses the right to operate semi-independently and to prescribe at least some medications (Bureau of Labor Statistics, 2010b). This high status is justified by numerous research studies, published in major medical journals, that have found care provided by advanced practice nurses to be as good as or better than that provided by doctors (Mundinger et al., 2000; Safriet, 1992; Sakr et al., 1999).

But even advanced practice nurses face limits imposed by medical dominance, as the case of nurse-midwifery illustrates. The earliest nurse-midwives, beginning in the 1920s, practiced primarily in poor or rural areas with few doctors and enjoyed considerable autonomy. Beginning in the 1960s, a growing number of nurse-midwives worked largely independent of doctors in homes and clinics, providing a true alternative to medicalized childbirth. These days, however, changes in insurance costs and regulations (supported by doctors) have made it impossible for nurse-midwives to work independently. Virtually all nurse-midwives now attend deliveries only in hospitals and only when doctors expect the delivery to be routine, uninteresting, and poorly paid even though research indicates that care by nurse-midwives (at home or in hospitals) is at least as safe as care by doctors in hospitals (MacDorman and Singh, 1999; Rooks, 1997:295–343).

On the other hand, nurse-midwives have legal authority to practice and to write prescriptions in all 50 states. Thirty-three states require private health insurers to reimburse nurse-midwives for their services, and all states reimburse midwives for serving **Medicaid** clients. In 2005, nurse-midwives attended 7% of all U.S. births (Martin et al., 2007).

In sum, nurse-midwives have gained considerable autonomy and public recognition, as well as an established place for themselves in the health care system. Their ability to gain greater professional status and independence from medical control, however, remains restricted.

Pharmacy: The Push to Reprofessionalize

Unlike nursing, pharmacy meets the three criteria (laid out in Chapter 11) that define a profession: the autonomy to set its own educational and licensing standards and to police its members for incompetence or malfeasance; a body of specialized knowledge, learned through extended, systematic training; and public faith that its work is grounded in a code of ethics. Like medicine, however, pharmacy's history illustrates how corporatization can limit an occupation's ability to retain crucial professional prerogatives. In addition, its history shows how medical dominance limits competing occupations' ability to maintain professional status.

Gaining Education, Losing Professional Prerogatives Pharmacists' role has changed considerably during the past half century, placing their professional status in jeopardy (Birenbaum, 1982). In the past, pharmacists needed complex skills to store, compound, and dispense the drugs that doctors prescribed. Now, however, pharmaceutical companies deliver drugs in forms suitable for dispensing, leaving pharmacists with few tasks other than counting, selling, and occasionally advising on drugs to consumers or health care providers. At the same time, whereas before about 1970 more than half of pharmacists owned their own businesses, now most work as employees of drugstore chains, supermarket chains, or hospitals. Incomes for pharmacists remain high, with a median income over $100,000 (Bureau of Labor Statistics, 2010b), but working conditions can be poor, especially in chain stores, where 12-hour shifts, staffing shortages, and pressure to fill prescriptions quickly are common (Stolberg, 1999). Like doctors, then, pharmacists are now more economically vulnerable than in the past; have less decision-making autonomy; and no longer set their own working conditions, own their tools or workspaces, or maintain individual relationships with clients.

As pharmacists' role has shrunk, however, their education has expanded. These days, all new pharmacists must complete 4 years of doctoral work in pharmacy—typically in addition to at least 3 years of college. These circumstances have created an identity crisis: Pharmacists consider themselves professionals but increasingly find their professional autonomy constrained (Birenbaum, 1982; Broadhead and Façchinetti, 1985).

The Growth of Clinical Pharmacy This identity crisis has stimulated interest among pharmacists in regaining their former level of professional status, or **reprofessionalizing**. To do so, since the early 1970s, pharmacists have called attention to research documenting high rates of dangerous drug errors and have argued that such errors could be reduced by giving pharmacists authority to review doctors' and patients' use of pharmaceutical drugs. This led to the development of the new field of clinical pharmacy. **Clinical pharmacy** is the practice of educating and employing pharmacists to advise doctors and patients on the use of pharmaceutical drugs (Franklin and van Mil, 2005). (The term *pharmaceutical care* is often used to refer to similar activities.) According to the American College of Clinical Pharmacy (2008:816),

> "the clinical pharmacist is recognized as providing a unique set of knowledge and skills to the health care system and is therefore qualified to assume the role of drug therapy expert, [whose] expertise is used proactively to ensure and advance rational drug therapy, thereby averting many of the medication therapy misadventures that ensue following inappropriate therapeutic decisions made [by doctors] at the point of prescribing."

The promoters of clinical pharmacy hoped that it would improve the status of pharmacists by increasing their professional autonomy, highlighting their specialized knowledge, and improving their status among the public. In addition, they hoped that the rise of clinical pharmacy would also improve pharmacists'

status by moving the more mundane tasks of storing and dispensing drugs to lower-level pharmacy technicians.

Clinical pharmacy has gained increasing support as concern has grown over both medical errors and spiraling health care costs. These concerns have led many hospitals, clinics, and **managed care organizations** to allow pharmacists to evaluate doctors' prescriptions, intervene before questionable prescriptions can cause harm or unnecessary expense, and work with patients to increase adherence to necessary drug treatments. Meanwhile, pharmacists working in community drug stores and, more often, large chain stores increasingly find that consumers turn to them as substitutes for or additions to medical advice (Abelson and Singer, 2010). (This has become especially problematic for pharmacists asked by customers about the emergency contraceptive Plan B, a topic discussed in *Ethical Debate: Pharmacists and Conscience Clauses.*)

Not surprisingly, the American Medical Association (AMA) has responded to the growth of clinical pharmacy by actively lobbying to define it as the unlawful practice of medicine (Agres, 2010).

The Impact of Managed Care As the above discussion suggests, **managed care** and **utilization review**, which have limited doctors' professional status, have increased the professional power and status of at least some pharmacists. Currently, pharmacists who work for health care corporations (including insurance plans, hospitals, and nursing homes) are involved in developing **practice protocols** for doctors to follow in prescribing drugs, in utilization review of doctors' prescribing practices, and in developing **formularies**—official lists of cost-effective drugs that doctors who are paid by insurance companies are expected to follow.

The rise of managed care also has improved pharmacists' position by stimulating growth in **disease management**. Disease management (sometimes known as health management) is a form of clinical pharmacy in which pharmacists are responsible for monitoring the use of prescription drugs by patients (typically those with chronic conditions that require constant attention to medication). Pharmacists engaged in disease management counsel patients; monitor the impact of medications on patients; and, in some circumstances, prescribe drugs themselves. Managed care organizations have adopted disease management as a way to control costs by preventing medication errors and by shifting care from doctors to lower-paid pharmacists (Abelson and Singer, 2010). Some states reimburse pharmacists under Medicaid for disease management, and more than half give pharmacists legal authority (in collaboration with physicians) to initiate or modify drug treatment.

Osteopathy: A Parallel Profession

Osteopathy exemplifies a health care occupation that has achieved professional status almost equal to that of medicine. Osteopaths function as **parallel practitioners**, performing basically the same roles as **allopathic doctors** while retaining professional autonomy and at least remnants of a fundamentally different ideology about illness causation (Gevitz, 1998). The history of osteopathy demonstrates the benefits and costs of gaining professional status in the face of medical dominance.

ETHICAL DEBATE

Pharmacists and Conscience Clauses

Sarah Johnson works as a pharmacist in a chain drug store in rural Washington state. She loves having the opportunity to help people deal with their health problems and enjoys her status as a competent, valued professional. Recently, though, her manager told her that she must stock and dispense Plan B, a drug that can be used after unprotected sex to prevent pregnancy by either preventing sperm from fertilizing an egg or (much less often) preventing a fertilized egg from implanting in a woman's uterus. Because federal regulations now allow Plan B to be sold without a prescription to anyone over age 17 but require pharmacists to keep it behind the counter, as the store's pharmacist she would have to physically hand the drug to any customers who request it and would have full responsibility (unmediated by a doctor) to instruct them in using it.

To many Americans, Plan B is a life saver that protects individuals from unwanted pregnancies (including those caused by rape). To others, Plan B is a life killer. Although many who oppose abortion believe that life doesn't start until after a fertilized egg is implanted in the uterus, others believe that life begins as soon as an egg is fertilized. To these individuals, Plan B is just another form of abortion, and abortion is just another form of murder. Moreover, Plan B seems particularly reprehensible because it allows individuals to end pregnancies quickly, cheaply, and safely, thus making abortion far more palatable and feasible than it might otherwise be.

Since abortion was legalized by the Supreme Court in 1973, most states have passed "conscience clauses" that permit health care students and professionals to opt out of learning or performing abortions or other tasks (such as sterilization or physician-assisted suicide) that they consider unethical (Berlinger, 2008). More recently, anti-abortion pharmacists and other activists have successfully pressed some states to pass conscience clauses that allow pharmacists to opt out of personally providing any drugs they consider unethical. Conversely, other states have passed laws that, at a minimum, require pharmacists to inform customers of other pharmacies that do stock and sell these drugs.

Nineteenth-Century Roots Osteopathy was founded by Andrew Taylor Still, a self-taught allopathic doctor (Miller, 1998). In 1864, three of his children died from meningitis. These deaths, coupled with his belief that all drug use was immoral, provoked Still to investigate alternatives to allopathic medicine. The system Still eventually developed drew on the popular contemporary concept of "magnetic healing" (Miller, 1998). **Magnetic healers** theorized that an invisible magnetic fluid flowed through the body and that illness occurred when that flow was obstructed, unbalanced, inadequate, or excessive. They believed that by moving their hands along patients' spinal cords, they could correct problems in the magnetic fluid and thus cure illness. Still adopted this theory essentially intact, although he attributed health and illness to problems in the flow of blood rather than the flow of magnetic fluid.

During the next few years, Still also studied the work of local bonesetters, whose work consisted primarily of setting broken and dislocated bones and joints and secondarily of treating joint problems through extending and manipulating limbs. Still's experiences convinced him that such manipulations could cure a wide variety of illnesses.

Pharmacists who believe on religious grounds that Plan B causes abortions and is therefore immoral argue that forcing them to provide the drug goes against their right to religious freedom (Flynn, 2008:105). Even if not phrased as a religious belief, they argue, professionals must have the right to refuse work that they consider unethical: If, for example, we expect military doctors to refuse orders to aid torturers, we should also not only allow but expect pharmacists to refuse orders that they believe aid murderers.

Others, however, argue that such refusals by pharmacists go against pharmacists' professional code of ethics (Flynn, 2008:105). According to the American Pharmacists Association's code, pharmacists are expected to "respect the autonomy and dignity of each patient." When a pharmacist refuses to dispense a drug that a customer requests, that pharmacist is implicitly deciding what is best for the customer and imposing his or her own moral and religious view on that customer. Moreover, in rural areas, and especially for poor customers who lack ready transportation, refusing to provide a drug may make it difficult or even impossible for a customer to obtain the drug in a timely manner (Berlinger, 2008).

In these situations, the integrity, autonomy, and religious freedom of customers and pharmacists are necessarily at odds.

Sociological Questions

1. What social views and values about medicine, society, and the body are reflected in the debate over pharmacists and conscience clauses? Whose views are these?
2. Which social groups are in conflict over this issue? Whose interests are served by requiring pharmacists to dispense drugs? By allowing them to refuse to do so?
3. Which of these groups has more power to enforce its view? What kinds of power do they have?

Combining magnetic healing and bonesetting, Still concluded that disease occurs when misplaced bones, especially in the spinal column, interfere with the circulation of blood. He named his new system of spinal manipulation *osteopathy*, from the Greek words for "bone" and "sickness." After the germ theory of disease became widely accepted, Still incorporated it into his theory by arguing that spinal problems predispose individuals to infections and that correcting spinal problems can help the body fight infection. To date, no research has demonstrated clearly whether osteopathic treatment has any effect, whether positive or negative. (The same, of course, can be said for most drugs and procedures used by allopathic doctors, as we saw in Chapter 11.)

Professionalizing Osteopathy In 1892, Still established the American School of Osteopathy and began accepting students for a four-month course of instruction. Five years later, in 1897, he helped found the American Osteopathic Association (AOA). The AOA fought hard to obtain professional recognition and autonomy for the field through increasing educational standards, gaining

state approval for independent osteopathic registration boards, and adopting and policing a code of ethics.

This fight proved highly successful. By 1901, and despite strong opposition from doctors and medical societies, 15 states legally recognized osteopathy. By 1923, osteopathic colleges required as many years of education as medical colleges, and all but two states licensed osteopaths. Nevertheless, although threats from allopathic medicine have failed to eliminate osteopathy, changes from within raise questions about its future as an independent field. By the 1920s, most osteopaths had concluded that to compete with allopathic doctors, they would have to offer a similar range of patient services. As a result, osteopaths increasingly treated patients with acute illnesses as well as those with chronic illnesses. In addition, osteopathic colleges continued to teach spinal manipulation but added courses in surgery and obstetrics, often taught out of medical textbooks. By the end of the decade, in a major break with its founder, the AOA mandated that osteopathic colleges provide a course in "supplementary therapeutics," including drugs. Thus, osteopathy began moving toward a merger with allopathic medicine (Miller, 1998).

Despite these changes, many allopathic doctors still disdained osteopaths. Although osteopathic education had improved, it had not kept up with the changes in allopathic education, leading many states to grant only restricted privileges to osteopaths. To combat this problem, the AOA adopted a series of reforms between 1935 and 1960, including requiring three years of college for admission to osteopathic colleges; improving the curriculum, facilities, and faculty at those colleges; and strengthening internship programs at osteopathic hospitals. Because of these changes, by 1960, osteopaths had received unrestricted privileges to practice in 38 states.

The Waning of Osteopathic Identity Despite these reforms, osteopaths still lacked the professional autonomy and status of allopathic doctors, who outnumbered them by at least 20 to one throughout the 1900s. This situation led osteopaths in California, the state where osteopathy was most entrenched, to strike a bargain in 1962 with their allopathic counterparts. Ninety percent of California osteopaths agreed to dissolve their ties with the AOA, stop using their osteopathic degrees, and accept new medical degrees. The California osteopathic hospitals and colleges agreed to become allopathic institutions, and the state osteopathic organization agreed that the state would stop issuing osteopathic licenses.

Although at the time many osteopaths worried that this move would weaken osteopathy, the reverse proved true (Gevitz, 1998). Many allopathic and osteopathic doctors alike opposed the merger, making any further mergers unlikely. In addition, the continuing professional problems of the former California osteopaths convinced osteopaths elsewhere that merging wouldn't end their problems. Thus, interest in pursuing a broader merger never developed. Meanwhile, both federal and state legislators and regulators interpreted AMA support for the merger to mean that osteopathic and allopathic doctors were essentially equivalent. Partly as a result, by the 1970s, osteopaths had

received unrestricted privileges in all 50 states and now have essentially the same relationship with insurance providers as do allopathic doctors. The number of osteopaths practicing in the United States has more than doubled over the past 30 years.

Osteopathy, then, no longer faces serious threats from the outside. Its existence remains threatened, however, by its success (Miller, 1998). Osteopaths now receive training and hospital privileges virtually identical to allopathic doctors and interact with the latter as equals. Although osteopaths occasionally use spinal manipulation, they generally use the same treatment modalities as allopaths. As a result, ties among osteopaths have faded, while those to allopathic doctors have grown. At the same time, the virtual elimination of differences between allopathic and osteopathic treatment and theory has reduced osteopaths' sense of a strong separate identity.

On the other hand, the growth of the consumer health movement and the rise of interest in alternative medicine since the 1970s have given a new burst of life to osteopathy. Modern consumers are increasingly sympathetic to osteopaths' orientation toward patient care, which in general is more holistic and humanistic than that found among allopathic doctors. In addition, consumers increasingly have sought less interventionistic treatments, such as osteopathic manipulation, either instead of or in addition to allopathic treatment. And osteopaths themselves are quick to point out these presumed differences between themselves and allopathic doctors, even as the differences have faded (Miller, 1998).

In sum, the history of osteopathy demonstrates the benefits of achieving full professional status as well as the difficulties a parallel health care profession can face in maintaining an independent identity when it no longer faces discrimination from the medical world and when the ideological justification for its separate existence wanes.

ALTERNATIVE HEALTH CARE PROVIDERS

The occupations described to this point all basically share allopathic medicine's understanding of how the body works, and all enjoy significant roles within the mainstream health care system. The occupations described in the remainder of this chapter are sufficiently divorced from mainstream American medicine to be considered **alternative** or **complementary therapies**—neither taught in medical schools nor widely used by doctors even if they sometimes are covered by health insurance.

With a few exceptions (such as chiropractic, direct-entry midwifery, and acupuncture), little is known about the effectiveness of alternative healing techniques, which include meditation, reflexology, faith healing, herbal therapies, and colonics. Because allopathic medicine has dominated the American health care system for so long, researching alternative therapies has been all but impossible. Scientific testing requires large investments of time and money, generally available only from the government, universities, or pharmaceutical companies. Until recently, researchers who wanted to study alternative techniques found it

nearly impossible to obtain funding, especially from pharmaceutical companies, which have no reason to fund research on herbs or techniques that they cannot patent. In addition, researchers who studied these techniques faced great difficulties in getting their results published in the prestigious medical publications that set the standards for health care practice.

In 1992, however, and in a major break with past policy, the U.S. Congress voted to establish within the National Institutes of Health a unit now known as the National Center for Complementary and Alternative Medicine. The major impetus for this legislation came from former California Congressman Berkley Bedell, who had experimented with alternative therapies after his doctors diagnosed him with terminal cancer. His apparently successful experiences convinced him that such treatments warranted wider study and use. Bedell's success in getting this legislation passed reflects legislators' recognition of both the soaring costs of mainstream medical care and the growing public interest in alternative health care.

Interest in alternative healing is growing not only among American consumers but also among allopathic doctors. Most medical schools now require some coursework in alternative medicine—often called "integrative medicine" in the medical world (Loviglio, 2005)—and many students choose to take electives in the area as well. In addition, growing numbers of doctors attend conferences and workshops on alternative therapies or even run alternative therapy centers at major hospitals and medical schools (Baer, 2010).

In the rest of this chapter, we examine four alternative health care occupations. The first two, chiropractic and lay midwifery, at least sometimes use the language of science to justify their work. The other two occupations, *curanderismo* and traditional acupuncture, draw on traditional beliefs unrelated to the Western scientific worldview.

Chiropractors: From Marginal to Limited Practitioners

Unlike osteopaths, **chiropractors** have fully retained their unique identity. The history of chiropractic illustrates how **marginal practitioners**, who treat a wide range of physical ailments and illnesses but have low social status, can become, like podiatrists, optometrists, and dentists, **limited practitioners**—nonmedical health care workers who gain greater social acceptance by confining their work to a limited range of treatments and bodily parts (Wardwell, 1979:230). *Key Concepts: Limited and Marginal Health Care Occupations* illustrates this distinction.

Early History The roots of chiropractic closely mirror those of osteopathy. Chiropractic was founded in 1895 by Daniel David Palmer, who coined the term from the Greek words for "hand" and "practice." Like Still, the founder of osteopathy, Palmer studied magnetic healing and spinal manipulation and concluded that spinal manipulation could both prevent and cure illness. However, whereas Still argued that spinal problems foster disease by restricting blood flow, Palmer argued that spinal problems foster disease by restricting nerves.

In 1896, Palmer founded the first chiropractic school to teach his techniques of spinal manipulation. By 1916, about 7,000 chiropractors had opened practices;

KEY CONCEPTS

Limited and Marginal Health Care Occupations

		Limited Range of Care	
		Yes	No
Marginal social position	Yes	Lay midwives	Traditional healers
	No	Chiropractors	Allopathic doctors

by 1930, that number had more than doubled, as schools opened around the country (Wardwell, 1988:159, 174).

The Fight Against Medical Dominance The American medical establishment greeted the emergence of chiropractic with the same hostility it had demonstrated toward osteopathy. To eliminate these competitors, the AMA and its regional organizations during the 1930s and 1940s filed lawsuits—many of them successful—against more than 15,000 chiropractors for practicing medicine without a license.

To further restrict chiropractic, the AMA pressed for legislation requiring prospective chiropractors to pass statewide basic science examinations written by allopathic-controlled boards. Ironically, this requirement strengthened rather than weakened chiropractic by forcing the field to raise its previously low educational standards. (As with early allopathic and osteopathic schools, early chiropractic schools accepted essentially all who could pay tuition and offered only a few months of training.) Standards improved most dramatically during the 1940s, when the National Chiropractic Association established accrediting standards for schools and when tuition money from veterans studying chiropractic under the federal GI Bill provided the funds schools needed to meet those standards. Since 1968, all chiropractic schools have required two years of college for admission, and most states require four years of chiropractic schooling for licensure.

Similarly, chiropractic in the end benefited from allopathic medicine's legal war against it. When **Medicare** first began in 1965, Congress bowed to pressure from the AMA and voted that Medicare would not cover services by chiropractors (or by clinical psychologists, social workers, physical therapists, and others in competition with doctors). Outraged chiropractic patients responded with a massive public letter-writing campaign, which led Congress in 1972 to pass legislation extending Medicare coverage to chiropractic services despite the lack of scientific research available at the time on its effects. This set the stage for state legislatures to require other insurance plans to reimburse for chiropractic care, at least in certain situations (Wardwell, 1988:179).

In 1974, the last of the 50 states passed legislation licensing chiropractors. Yet organized medicine continued to limit the ability of chiropractors to practice freely. In addition to fighting legislation designed to allow chiropractors to receive

private insurance reimbursement, the AMA banned contact between chiropractors and allopaths, making it impossible for chiropractors and allopaths to refer patients to each other. In response, chiropractors and their supporters filed antitrust suits in the late 1970s against the AMA, various state medical associations, the American Hospital Association, and several other representatives of organized medicine (as well as the AOA), alleging that these organizations had restrained trade illegally. Chiropractors and their defenders eventually won or favorably settled out of court all the suits. As a result, overt opposition to chiropractic ended.

Current Status These changes have allowed chiropractors to solidify their social position. A 2007 national random survey found that 8.6% of U.S. residents had used chiropractic (or osteopathic) manipulation in the previous 12 months (Barnes, Bloom, and Nahin, 2008). (This survey did not differentiate between chiropractors and osteopaths, but a parallel survey conducted in 2002 found that 7.5% reported using chiropractors alone). For the past 30 years, the 16 U.S. schools of chiropractic have continued to graduate increasing numbers of students. About 50,000 chiropractors work in the United States, most in solo practice (Bureau of Labor Statistics, 2010b). The mean annual income for chiropractors is $94,000—considerably below physicians' incomes but for a much shorter workweek and with much less, and less expensive, education required to enter the field (Bureau of Labor Statistics, 2010b). These figures alone suggest chiropractic's success.

That success, however, is bounded by chiropractors' status as limited practitioners. Insurers now often pay for chiropractic services—about half of the people who use chiropractic services have full or partial coverage—but usually will do so only for treating specific conditions in specific ways (Tindle et al., 2005). State licensure laws sometimes set similar limits, as does patient demand: Despite many chiropractors' desire to treat a broader range of problems, most patients visit them solely for treatment of acute back, head, or neck pain. In addition, only 5% of chiropractic patients are referred by a medical doctor, clearly indicating that doctors do not regard chiropractors as colleagues (Mootz et al., 2005).

Nevertheless, chiropractors continue to push for a wider role in health care. Many chiropractors believe spinal problems underlie all illness and that spinal manipulation can cure most health problems, from asthma to cancer. As a result, they believe they can serve effectively as **primary care** providers and now advertise heavily that they offer care for the whole family throughout the life course. This has stimulated new conflicts with mainstream medicine, especially because a significant minority of chiropractors oppose medical treatments, drugs, and vaccination (Campbell, Busse, and Injeyan, 2000). *Contemporary Issues: Vaccine Refusal* discusses the risks incurred when children are not vaccinated.

Current research suggests that chiropractic care may provide slight help to those with acute lower back pain but is unlikely to help others (Cherkin et al., 1998; Hadler, 2008). Nor does it seem likely that future research will identify more benefits given that the basic principles of chiropractic simply do not mesh with scientific understandings of human biology.

CONTEMPORARY ISSUES

Vaccine Refusal

As memories of measles and other infectious disease epidemics have faded, growing numbers of parents have decided against vaccinating their children (Omer et al., 2009; Steinhauer, 2008). These decisions may stem from Internet rumors, religious or philosophical beliefs, or skepticism regarding modern medicine (sometimes fueled by chiropractors). Although scientific support for vaccination is overwhelming (Roush et al., 2007; Stratton, Wilson, and McCormick, 2002), parents and practitioners may nonetheless question the safety of vaccinating young children with dead or weak strains of disease-causing viruses. Others believe in vaccination but question the wisdom of simultaneously injecting children with multiple vaccinations. Still others believe—based on an article published in the prestigious *British Medical Journal* that was later proved fraudulent—that vaccination can somehow cause autism (Steinhauer, 2008; Godlee, Smith, and Marcovitch, 2011).

The rise in vaccine refusal has led to outbreaks of measles and other diseases in the past few years. Although a disease such as measles, for example, may seem to be merely a nuisance, some who become infected develop ear infections, pneumonia, and encephalitis, and some of the infected become permanently deafened or even die as a result. Moreover, whenever an unvaccinated child becomes infected with a disease, he or she can spread the disease to adults whose vaccinations have worn off with time and to children who cannot be vaccinated because their immune systems are too weak (either because of illness or chemotherapy or because they are younger than one year old). Currently, all states allow parents to opt out of vaccination for religious or medical reasons (such as pre-existing illness), and a growing number of states allow parents to opt out based on any personal beliefs.

Direct-Entry Midwives: Limited But Still Marginal

The history of direct-entry midwifery shows the difficulties members of an occupation face in gaining acceptance as limited practitioners when the occupation draws only from socially marginal groups—in this case, women, often from minority groups. Although until the twentieth century, **direct-entry midwives** (i.e., midwives who lack nursing degrees) delivered the majority of American babies, by 2005, direct-entry midwives delivered fewer than 0.5% of all babies (Martin et al., 2007). In this section, we consider how these changes came about and how direct-entry midwives have attempted to regain their lost position.

The Struggle to Control Childbirth Until well into the nineteenth century, Americans considered childbirth solely a woman's affair (Wertz and Wertz, 1989). Almost all women gave birth at home, attended by a direct-entry midwife or by female friends or relatives. Although a few local governments during the colonial era licensed midwives, licensure laws did not survive past U.S. independence, so anyone who wanted to call herself a midwife could practice essentially without legal restrictions. Unlike nurse-midwives, who did not exist until the twentieth century, these **direct-entry midwives** had no formal training but rather learned their skills through experience and, sometimes, through informal apprenticeships. Typically, they served only women from their own geographic

or ethnic community. Doctors (all of whom were men) played almost no role in childbirth because Americans suspected the motives of any men who worked intimately with female bodies (Wertz and Wertz, 1989:97–98). Moreover, doctors had little to offer childbearing women beyond the ability to destroy and remove the fetus when prolonged labor threatened to kill the mother. Midwives, meanwhile, could offer only patience, skilled hands, and a few herbal remedies.

During the late nineteenth century, Americans' willingness to have doctors attend childbirths gradually increased, as did doctors' interest in doing so. As described in Chapter 11, nineteenth-century allopathic doctors faced substantial competition not only from each other but also from many other kinds of practitioners. As a result, doctors attempted to expand into various fields, from pulling teeth to embalming the dead to assisting in childbirth (Starr, 1982:85). Doctors considered assisting in childbirth especially crucial because they believed that families who came to a doctor for childbirth would stay with him for other services (Wertz and Wertz, 1989:55).

As Americans' belief in science and medicine grew during the late nineteenth century, medical assistance in childbirth became more socially acceptable among the upper classes (Starr, 1982:59). Many women supported this change because it allowed them to obtain painkillers from doctors without feeling guilty for circumventing the biblical command to bring forth children in pain (Wertz and Wertz, 1989:110–113). In addition, because midwifery was not a respectable occupation for Victorian women, by the late nineteenth century, middle- and upper-class women seeking a childbirth attendant had only two options: lower-class lay midwives or doctors of their own social class. Having a doctor attend one's childbirth thus could both reflect and increase one's social standing (Leavitt, 1986: 39; Wertz and Wertz, 1989). Ironically, however, doctors probably threatened women's health more than did midwives; although inexperienced or impatient midwives certainly could endanger women, doctors more often used surgical and manual interventions that could cause permanent injuries or deadly infections (Leavitt, 1983:281–292, 1986:43–58; Rooks, 1997).

Doctors' desire to obtain a monopoly on childbirth care led them, beginning in the mid-nineteenth century, to voice opposition to midwives. These attacks escalated substantially in the early twentieth century (Sullivan and Weitz, 1988:9–14). Recent waves of immigrants had swelled the ranks of midwives and made them more visible and threatening to doctors, whose status, especially in obstetrics, remained low. Moreover, doctors now needed the business of poor women as well as wealthier women because the rise in scientific medical education had created a need for poor women patients who could serve as both research subjects and training material.

To expand their clientele, doctors attempted through speeches and publications to convince women that childbirth was inherently and unpredictably dangerous and therefore required medical assistance. In addition, doctors played on contemporary prejudices against immigrants, African Americans, and women to argue that midwives were ignorant, uneducable, and a threat to American values and that therefore midwifery should be outlawed. For example, writing in the *Southern Medical Journal*, Dr. Felix J. Underwood, the director of the Mississippi

Bureau of Child Hygiene, described African American midwives as "filthy and ignorant and not far removed from the jungles of Africa, with its atmosphere of weird superstition and voodooism" (1926:683).

Although these campaigns cost midwives many clients, they had little effect on the law. Many members of the public, and even many doctors (particularly those in public health), believed that trained midwives could provide satisfactory care, at least for poor and nonwhite women who couldn't afford doctors' services. Consequently, laws passed during this era tended to have quite lenient provisions. In the end, however, imposing lenient laws, rather than laws requiring upgraded midwifery training and skills, resulted in the deterioration of midwifery and its virtual elimination. The only exceptions were in immigrant and nonwhite communities in the rural South and Southwest, where traditional midwives continued to conduct home births until at least the 1950s (Sullivan and Weitz, 1988:13–14).

The Resurgence of Direct-Entry Midwifery By the second half of the twentieth century, childbirth had moved almost solely into hospital wards under medical care. Although childbearing women were grateful for the pain relief and safety that doctors promised, all too often women nonetheless found the experience painful, humiliating, and alienating. Despite the absence of scientific support for such practices, doctors routinely shaved women's pubic areas before delivery, strapped them on their backs to labor and delivery tables (the most painful and difficult position for delivering a baby), isolated them from their husbands during delivery and from their infants afterward, and gave them drugs to speed up their labors or make them unconscious—all practices that scientific research would eventually find unnecessary or dangerous (Sullivan and Weitz, 1988).

Objections to such procedures sparked the growth of the natural childbirth movement during the 1960s and 1970s and forced numerous changes in obstetric practices. Most hospitals, for example, now offer natural childbirth classes. Critics, however, argue that the real purpose of these classes is to make women patients more compliant and convince them that they have had a natural childbirth as long as they remain conscious even if their doctors use drugs, surgery, or forceps (Sullivan and Weitz, 1988:39).

By the late 1960s, many women had concluded that hospitals would never offer truly natural childbirth (Sullivan and Weitz, 1988:38–39). As a result, a tiny but growing number of women chose to give birth at home. For assistance, they turned to sympathetic doctors and to female friends and relatives, some of whom were nurses. Over time, women who gained experience in this fashion might find themselves identified within their communities as midwives. This new generation of direct-entry midwives who attend almost solely home births reflects the broader revolt against medicalized birth (Sullivan and Weitz, 1988:23–59).

Working as a direct-entry midwife means long and uncertain hours with little pay. Most midwives, however, are motivated by humanitarian and philosophical concerns rather than by financial gain (Simonds, Rothman, and Norman, 2007). Although midwives recognize the need for obstetricians to manage the complications that occur in about 10% of births, they fear the physical and emotional dangers that arise when obstetricians use interventionist practices,

developed for the rare pathological case, during all births. Like nurse-midwives, direct-entry midwives strongly believe in the general normalcy of pregnancy and childbirth and in the benefits of individualized, holistic maternity care in which midwife and client work as partners.

No national laws set the status of direct-entry midwives. As of 2008, direct-entry midwifery was legal in 35 states and prohibited in ten, with its status elsewhere unclear (Midwives Association of North America, 2010). In states where midwifery is illegal, midwives run the risk of prosecution for practicing medicine without a license and for child abuse, manslaughter, or homicide if a mother or baby suffers injury or death. Yet research strongly suggests that home births conducted by experienced direct-entry midwives working with low-risk populations are as safe as or safer than doctor-attended hospital births even taking into account the small number of midwifery clients who develop problems needing medical attention (Johnson and Daviss, 2005; Lewis, 1993).

In states where direct-entry midwifery is legal, midwives typically must abide by regulations restricting them to "low-risk" clients (such as women younger than age 35) and restricting the techniques they can use (such as forbidding them from suturing tears after deliveries). These midwives typically must have a backup doctor and must transfer their clients to medical care if the doctor so orders. Thus, legalization has given midwives some degree of freedom to practice in exchange for limited subordination to medicine (Sullivan and Weitz, 1988:97–111).

Despite evidence such as this, medical opposition to direct-entry midwifery remains strong and public support weak, although insurance companies do cover midwifery services in some states. Thus direct-entry midwives, even where legal, cannot claim to have achieved social acceptance even as limited practitioners.

Curanderos

Curanderos are folk healers who function within Mexican and Mexican American communities (DeBellonia et al., 2008; Perrone, Stockel, and Krueger, 1989; Roeder, 1988). In the United States, curanderos are used primarily by immigrants, as well as by some U.S.-born Mexican Americans, especially those who live in close-knit communities in the Southwest. Those who use curanderos rarely reject modern medicine. Instead, they seek curanderos when medical care fails to cure illness, when distance or poverty limits access to medical care, or when fear of deportation keeps them from seeking medical care (Sack, 2008b). Use of curanderos appears to have risen lately because of the downturn in the U.S. economy and the crackdown on undocumented immigrants (Sack, 2008b). The former has made it difficult for some to afford mainstream health care, whereas the latter has led some to avoid mainstream health care for fear that they will be reported to immigration authorities.

Theories and Treatments Curanderos recognize both Western categories of disease, such as colds, and categories of illness unique to Hispanic culture, such as *susto* (DeBellonia et al., 2008; Roeder, 1988). A common diagnosis, *susto* refers to an illness that occurs when fright "jars the soul from the body, in which case treatment

consists of calling the soul back" (Roeder, 1988:324). Curanderos also sometimes trace illness to supernatural forces such as *mal de ojo*, or the evil eye.

Curanderos treat illness in a variety of ways, including herbal remedies, massage, prayer, and rituals designed to combat supernatural forces. They believe illness reflects all aspects of an individual's life—biology, environment, social setting, religion, and supernatural forces—and thus must be treated holistically. As a result, curanderos often spend considerable time listening to their clients. The successes curanderos sometimes achieve in treating their clients' illnesses thus derive not only from their knowledge of herbs and the healing powers of their clients' faith but also from the simple healing power of a sympathetic listener. At the same time, curanderos' lack of scientific knowledge can threaten health when, for example, they use folk remedies that contain mercury, lead, or other toxins (DeBellonia et al., 2008).

Becoming a Curandero Individuals become curanderos through apprenticeships, typically with family members. Successful curanderos find that their practices evolve gradually from part-time work, paid primarily in goods and services, to more or less full-time, cash businesses.

The story of Gregorita Rodriguez, a *curandera* (female curandero) living in Santa Fe, New Mexico, who specializes in massage treatments, illustrates this process:

> Gregorita traces her own career as a *curandera* back to her grandmother, Juliana Montoya, who taught Gregorita's aunt, Valentina Romero, the art of *curanderismo*. When any of Gregorita's seventeen children became ill, she took them to her Aunt Valentina for treatment. *La curandera* taught Gregorita, encouraging her by asking, "Why don't you learn? Look, touch here." Using her children's bellies as a classroom, Gregorita felt the different abdominal disorders and learned how to manipulate the intestines to relieve the ailments.
>
> Another of her patients during this learning period was her husband. Responding to his complaints, Gregorita said, "Maybe I can do something for you." Mr. Rodriguez replied, "No, no, no! You are not going to boss me!" So, off he went to see Aunt Valentina, who was elsewhere delivering a baby. Finally, Gregorita got her chance. Her husband was desperate and allowed her to learn, all the time howling about how much she was hurting him. "Cranky," she described him, "especially when I felt a big ball in his stomach and had to work very hard. Slow, slow, I fixed him and he got better. When he went to my aunt, she said he was okay now. After that I treated my husband and one of my sisters and then her family. That's the way it started" (Perrone et al., 1989:108–109).

After this incident, others began coming to Gregorita for treatment, and she soon found herself accepted as a curandero.

The Impact of Medical Dominance Because they lack any recognized training in health care, curanderos cannot legally charge fees or bill insurance companies for payment. Some work for free, others for fees ranging from $10 to $100. Most keep a low profile, obtaining clients only through word of mouth and only

within the Hispanic community. As this suggests, even a folk healer who appears to function completely outside the bounds and control of the Western scientific world cannot avoid its authority altogether.

That said, some hospitals and clinics in heavily Hispanic areas now invite curanderos to perform ritual healings (or "cleanings") for their patients. Doing so, they hope, will reduce patients' stress levels, increase their satisfaction with care, and thus increase the likelihood that they will recommend the hospital to others (Brown, 2009). As this suggests, curanderos cannot completely escape medical dominance, but as the Hispanic population grows, neither will medical institutions be able to totally reject curanderos.

Acupuncturists

Theories and Treatments If anything, acupuncturists' ideas regarding health and illness bear even less relationship to Western medicine than do curanderos' ideas. Acupuncture is one of the oldest forms of healing known. Its recorded history goes back 2,000 years, with strong prehistorical evidence going back to the Bronze Age.

Like all traditional Chinese medicine, acupuncture is based on the concept of *chi*. This concept, which has no Western equivalent, refers to the vital life force, or energy. Health occurs when *chi* flows freely through the body, balanced between *yin* and *yang*, the opposing forces in nature. Because any combination of problems in the mind, body, spirit, social environment, or physical environment can restrict *chi*, treatment must be holistic.

Following this theory, traditional Chinese healers consider both symptoms and diagnosis unimportant and focus instead on unblocking *chi*. Acupuncture is based on the theory that *chi* runs through the body to the different organs in channels known as meridians, which have no Western equivalents. To cure a problem in the colon, for example, acupuncturists apply needles to the index finger, which they believe connects to the colon via a meridian. In this way, they believe, they can stimulate an individual's *chi* and direct it wherever it is needed. Acupuncturists decide on treatment through taking a complete history, palpating the patient's abdomen, measuring his or her blood pressure, and reading the 12 pulses recognized by Chinese medicine.

Acupuncture is still used extensively in China, both alone and in conjunction with Western medicine, and is used increasingly in the West. To ascertain its impact, the U.S. National Institutes of Health organized a Consensus Development Panel on Acupuncture in 1998. (A consensus panel is a group of experts from diverse backgrounds brought together to reach joint conclusions on a topic.) The panel's final report concluded that acupuncture can alleviate nausea and pain but does *not* help individuals to stop smoking. The report also noted that acupuncture has fewer harmful side effects than modern medicine does and that many accepted Western medical practices lack scientific support. The World Health Organization (2003), meanwhile, considers acupuncture effective and safe for relieving anxiety, panic disorders, insomnia, postoperative and dental pain, and nausea caused by pregnancy or chemotherapy.

The Impact of Medical Dominance Widespread American interest in acupuncture began during the 1970s, when the People's Republic of China first opened to U.S. travelers. Early travelers brought back near-miraculous tales of acupuncture anesthesia and treatment. Because American doctors had no scientific model that could account for acupuncture's effects, these tales threatened their position and worldview (Wolpe, 1985). As a result, various well-known doctors publicly denounced acupuncture, claiming it worked only as a placebo or only because Chinese stoicism or revolutionary zeal allowed them to ignore pain even though acupuncture also had worked on animals and on Western travelers to China.

To remove this threat to their cultural authority, doctors endeavored to control the definition, study, and use of acupuncture (Wolpe, 1985). This proved relatively easy because, unlike chiropractic or osteopathy, acupuncture at the time had few American supporters. Consequently, in their writings and public pronouncements, doctors could strip acupuncture of its grounding in traditional Chinese medical philosophy and define it simply as the use of needles to produce anesthesia. Pressure from medical organizations led the National Institutes of Health to adopt a similar definition in funding research on acupuncture. At the same time, pressure from doctors led most states to adopt licensure laws allowing any doctors, regardless of training, to practice acupuncture but forbidding all others, no matter how well trained, from doing so except under medical supervision. Thus, for many years, most traditional acupuncturists in the United States worked illegally within Asian communities.

During the past decade, however, as acceptance of alternative healing traditions has increased, the position of acupuncturists has improved. Some insurance companies will reimburse nondoctors for acupuncture treatments, and most states now allow nondoctors to perform acupuncture, although some of these states require medical supervision or require acupuncturists to be licensed by medically dominated boards. Use of acupuncture remains rare: only 1.4% of U.S. residents report using it during the past 12 months (Barnes et al., 2008). Surprisingly, about half of acupuncture users report receiving some insurance coverage for it (Tindle et al., 2005). Despite this small indication of increasing acceptance, these figures suggest that acupuncture remains a marginal therapy and occupation, posing little threat to medical dominance.

IMPLICATIONS

As the discussions in this chapter have suggested, the health care arena is much broader than we usually recognize. Many alternatives to medical treatment exist far beyond those discussed herein. Most of these alternatives function not so much in opposition to mainstream health care as in parallel, with those seeking care jumping back and forth across the tracks. For example, a woman might deliver her first child with a doctor, her second with a nurse-midwife, and her third with a direct-entry midwife, whereas a man who experiences chronic back

pain might see a chiropractor or acupuncturist either before, after, or in addition to seeing a medical doctor.

This chapter has highlighted the factors that help health care occupations gain professional autonomy in the face of medical dominance. Timing certainly seems to play a role: Those occupations that emerged before medical dominance became cemented, such as osteopathy and chiropractic, have proved most successful. Social factors, too, consistently seem important: Health care occupations with roots in and support from higher-status social groups have a better chance of winning professional autonomy than do those with lower-status roots and supporters.

Other occupations seem to retain some autonomy—if a marginal position in the health care arena—because they pose little threat to medical dominance. Curanderos, for example, attract a small clientele of poor Mexicans and Mexican Americans who might not be able to pay for medical care or to communicate effectively with medical doctors anyway. Doctors thus have little incentive to eliminate curanderos' practices. Acupuncturists, on the other hand, have attracted not only Asians and Asian Americans but also well-educated whites—including individuals with the skills and resources to publicize the virtues of acupuncture. Consequently, doctors have had a far greater vested interest in restricting acupuncturists' practices and in co-opting acupuncture for their own purposes.

Not surprisingly, developing professional autonomy seems most difficult for those, such as nurses, who work directly under medical control. In contrast, groups such as chiropractors have considerably more leeway to develop their practices without interference from medical doctors.

Finally and ironically, strict licensing laws, even when devised by doctors opposed to an occupation's growth, in the end can help occupations gain professional autonomy by forcing them to increase standards and thereby enabling them to gain additional status and freedom to practice.

To date, medical doctors have succeeded in retaining their professional autonomy and dominance partly because of their greater ability to provide scientific data supporting their theories and practices—or at least to convince the public that they have such data. It remains to be seen whether increased federal support for research on alternatives will increase scientific credibility and public support for these practices.

SUMMARY

1. Nursing as a field has tried to improve its status primarily by increasing educational requirements. It has been held back by its status as a "female" occupation and by public expectations that women are naturally caring and thus do not need professional salaries, professional status, or good work conditions in exchange for their caregiving.
2. The emphasis on higher education has reinforced nursing's hierarchical structure and alienated nurses who lack higher degrees. Meanwhile, corporatization and the emphasis on cost cutting has worsened nurses' working conditions.