CAM within a field force of countervailing powers: the case of Portugal

Abstract

This paper examines the extent to which the position of the medical profession and the state towards complementary and alternative medicine (CAM) practitioners has changed since the late 1990s, taking Portugal as a case study. Using Light's concept of countervailing powers, we consider the alliances, interests, rhetoric and degrees of control between these three actors over time, focusing particularly on the extent to which CAM practitioners have acted as a countervailing force in their relationship with the medical profession and the state. It also brings to the fore the position of supra-state agencies concerning CAM regulation. A critical discourse analysis was conducted on data derived from a systematic search of information dating from the late 1990s up to 2015. Our analysis suggests that CAM has emerged as an active player and a countervailing power in that it has had significant influence on the process of state policy-making. The medical profession, in turn, has moved from rejecting to 'incorporating' CAM, while the state has acted as a 'broker', trying to accommodate the demands and preferences of both actors while simultaneously demonstrating its power and autonomy in shaping health policy. In sum, the history of countermoves of CAM, the medical profession and the state in recasting power relations regarding CAM regulation in Portugal has highlighted the explanatory value of Light's countervailing power theory and the need to move away from a professional dominance and corporatist approach, in which CAM has simply been seen as subjugated to the power of the medical profession and the state.

Keywords: Portugal; complementary and alternative medicine; medical profession; state; countervailing powers; professions regulation; policy process

1. Introduction

In recent years complementary and alternative medicine (CAM) has achieved greater state legitimacy in Western society. Acupuncture, homeopathy, osteopathy, chiropractic, naturopathy and herbal medicine have sought statutory recognition in countries such as Canada (Kelner et al., 2006), Australia (Baer, 2006), the USA (Baer et al., 1998; Saks, 2003) and the UK (Saks, 2015; Cant & Sharma, 1996). This has not always been the case, however. It was only in the second half of the 20th century that the state's interest in CAM started to increase (Saks, 2015), and that new professional groups such as CAM practitioners emerged and attempted to pressure the state into legitimising their claims (Baggott, 2004; Timmermans & Berg, 2003). The success of the legitimacy claims of CAM within orthodox healthcare has crucially depended on the support of the modern state (Kelner et al., 2006; Saks, 2003).

The pressure to legitimise CAM therapies has also come from bodies working at a supranational level. The *World Health Organisation* (WHO) and the *Council of Europe* have encouraged states in the West to establish an adequate legal framework for CAM and to integrate it into their national healthcare systems. The success of this strategy has been helped by many Western governments focusing their health policies on a public health agenda, hence paying attention not only to ill-health and disease but also to providing the conditions for maintaining a healthy population (Hunter, 2003). As a result, a number of Western states have stopped dismissing CAM and become more sympathetic to the aspirations of CAM practitioners.

In Portugal, little consideration has been given by social researchers to the process of legitimating CAM and the interaction between CAM practitioners, the state, political parties and the medical profession. This interaction is of particular interest for two main reasons: firstly, statutory regulation has been one of the main resources used by CAM practitioners to

acquire legitimacy within orthodox healthcare; secondly, however, the idiosyncratic way in which CAM legislation has been enacted in Portugal since the late 1990s reflects the difficult bargaining relationship between the state, the medical profession and CAM, and has resulted in a delay in CAM legislation.

In light of the above it is important to establish the extent to which the Portuguese state and the medical profession have been sympathetic towards the acceptance of CAM practitioners' aspirations within orthodox healthcare. This requires an analysis of the specific political context within which CAM practitioners have operated and the role of the Portuguese state in facilitating or constraining the success of their professional strategies. The analysis will begin in the late 1990s, when the CAM regulation process, underway at the time of writing, began.

1.1. The field of countervailing powers

Despite the overall increase of state interest in CAM in Western countries, the regulation of CAM has involved country-specific dynamics and in many cases has been the result of strategic power relations between interest groups over an extended period of time. In order to analyse these power relations, a sociological approach which sees these groups as operating within a field force of countervailing powers will be adopted (Light, 2000).

Light's concept of 'countervailing powers' is considered a 'theoretical hybrid', in that it suggests a pluralistic perspective on power in the healthcare arena, thus moving away from functionalist, Marxist and Weberian power frameworks (Riska, 2001). Light (2000: 203) refers to 'countervailing powers' as the interaction of 'powerful actors in a field where they are inherently interdependent yet distinct'. That is, countervailing powers involve counteractions being taken by certain actors in order to restore the balance of power in the market. Each of these interdependent actors is competing within a certain field (health, for

example) and constantly negotiating power, status, market opportunities and money (Light, 2010).

Light (2010: 271) gives prominence to the power of the state which '… may hide unfolding tensions and countermoves [from other actors]'. Dunleavy and O'Leary's (1987) conceptualisation of the state as a broker complements Light's perspective on the state as a countervailing force. The state acts as a broker in that, despite being pressurised by different stakeholders, it does not just mirror society or follow the public and professional interest in a neutral way. Rather, as Greenberg (1990: 29) has emphasised, the state is 'an independent and powerful entity capable not only of holding off powerful social forces, but of imposing its own vision and goals upon them.'

Light (1995) also addresses strategic allegiances between certain partners, as discussed below.

1.2. 'Strategic alliances' between countervailing powers

According to Light (1995), the multi-dimensional character of the countervailing parties allows for the creation of alliances between two or more parties in order to enhance their power. Within the healthcare field, for example, Degele (2005:112) has pointed out that biomedical power is not justified solely by scientific evidence of effectiveness, but is also the result of the interpenetration of 'scientific pressure groups, professional, and socioeconomic interests' which sponsor its dominant ideology. Goldstein (2002) has also shown how the corporate sector has capitalised on CAM, as the latter can offer potential cost savings. Low-cost alternatives like CAM therapies have encouraged corporations such as private health insurance companies to extend coverage to one or another form of CAM.

In regard to the state, as Light (2010: 271) puts it, it is '… a constellation in itself of countervailing power groups or divisions with different functions and priorities'. Certain political parties, for example, can forge alliances with emerging occupational groups (CAM, for example) in order to challenge the political order and the orthodox healthcare system.

So, in the health arena, the framework of countervailing powers enables us to analyse the 'embeddedness of the interplay between health professions and the state' (Burau, 2014: 2) and the changes in this interplay over an extended period of time. It considers the changing tensions, alliances, interests, rhetoric and degrees of control among different actors over time. We will next look at CAM as existing in a field force of countervailing powers.

1.3. CAM in a field of countervailing powers

There has been relatively little empirical sociological research on CAM as an emerging and successful countervailing power in the healthcare field. Kelner et al.'s (2006) study of chiropractors and homeopaths in Ontario, Canada constitutes an original contribution to the countervailing powers model in that it shows how the social context influences the ways in which the state responds to CAM practitioners' attempts to acquire legitimacy. As Kelner et al. (2006: 2625) affirm, 'the interplay between the group [CAM], the other health professions, the state, and the public, determines how far an occupation can go in the professionalising process'.

However, although Kelner et al. (2006) have made use of the concept of countervailing powers to place CAM within a larger institutional and cultural context, they do not pay much attention either to the state as a powerful and autonomous stakeholder or to CAM as a successful countervailing force. Rather, they explain how medicine, as the dominant interest group, interacts to constrain the progress of chiropractors and homeopaths in Canada. They

emphasise the power of the medical profession over the government: 'if medicine can continue to convince government and the public of these arguments, these CAM occupations will be denied adequate financial resources to pursue key strategies' (Kelner et al., 2006: 2625). The Canadian state, according to Kelner et al. (2006; 2004), had been constrained by institutional and social forces and, although sympathetic to CAM, continued to act with caution in relation to CAM legitimacy. More recently, however, research (Welsh & Boon, 2015) on CAM regulation in Ontario, Canada has shown that the Canadian state passed new legislation in 2013 to regulate three selected CAM therapies: traditional Chinese medicine, naturopathy and homeopathy. CAM practitioners, in turn, have found it easier to move from the margins of the healthcare system.

The role of the state as a countervailing force can be illustrated by its demand for CAM to create professional umbrella bodies in order to achieve greater internal cohesion and standardised training. Usually it has been through the creation of these regulatory bodies and the application of standardised, evidence-based guidelines (Timmermans & Berg, 2003) that government authorities have enacted the regulation of CAM. This has been highlighted in the case of the British state's response to acupuncture and homeopathy, which are the most professionalised CAM therapies in Britain, after osteopathy and chiropractic (Cant & Sharma, 1996). Similar state demands for organisational cohesion and standardisation of CAM can be found in other countries such as Canada – in particular, regarding naturopaths, acupuncturists and homeopaths (Gilmour et al., 2002) – and the USA – regarding acupuncture (Baer et al., 1998; Goldstein, 2002).

As for the medical profession, whilst it appears that it still responds to CAM with exclusionary and demarcationary strategies – for example, by expressing concerns about scientific evidence for CAM – it has tended increasingly to reduce its resistance to CAM (Kelner et al., 2006, Cant & Sharma, 1996). Saks (1995) illustrated this shift in medicine's

147 reception of CAM in the case of acupuncture in Britain by showing that, by the mid-1970s,
148 this therapy had moved from a position of rejection to one of increasing medical
149 incorporation. In the same vein, Cant and Sharma (1996) showed how the incorporationist
150 strategy of the medical profession has meant a loss of professional autonomy for British
151 homeopathy. Baer (2004) in turn has portrayed acupuncture and homeopathy in the USA as
152 professionalised and partially professionalised heterodox medical systems respectively,
153 which have been granted legitimacy at the cost of a subtle process of co-option or absorption
154 by biomedicine.

155 From a countervailing power theory perspective, it seems that in the aforementioned
156 countries, CAM, the state and the medical profession have negotiated for influence in
157 healthcare and have acted as countervailing forces, simultaneously opposing and allying with
158 each other. With this in mind, in this paper we assess: (1) the degree to which CAM
159 practitioners have influenced policy-making in Portugal and thus acted as a countervailing
160 source of power, and (2) the extent to which the Portuguese state has sustained CAM
161 practitioners' attempts to acquire legitimacy within orthodox healthcare. Third, and finally,
162 we will also consider possible changes in the medical profession's view of CAM practice and
163 CAM practitioners.

164

165 **2. Methods**

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167 *2.1. Data collection*

168 The study presented here is part of a wider research project exploring the relationship
169 between CAM, the medical profession and the state in Portugal. The main sources of data
170 were in-depth interviews with medical doctors and medically qualified and non-medically
171 qualified acupuncturists and homeopaths, and documents. Documents were used because they

provide a key source of information on historical and political processes such as CAM statutory regulation in Portugal.

In this paper, attention will be focused only on documentary data. The data were mostly generated by systematic searches of information on Web search engines such as Google, published between the late 1990s and 2015. The first author used key search phrases such as 'CAM regulation in Portugal', 'CAM and the medical profession' and 'non-conventional therapeutics and the Portuguese state'. Other documents were obtained first-hand by the first author from clinical settings and interviewees. Documents searched and obtained included specialised journals and magazines like the Portuguese Medical Council's Journal, newspapers, letters, legislation, official reports from governmental bodies and professional associations, and audio materials such as radio interviews.

The authors focused mainly on documentary data from CAM actors and institutions, medical actors and institutions, and the state. Although the authors recognise that supranational agencies play a potential role in CAM legislation, the study reported here focuses on a national rather than a supranational level of analysis, and so systematic data collection from supranational agencies was not considered. In the same vein, the authors acknowledge the potential worldwide importance of the general public as advocates of CAM legislation, although in Portugal grassroots CAM movements have been weak, so systematic data collection addressing this actor was not undertaken.

2.2. Documentary analysis

As Prior (2008) acknowledges, documents are not just receptacles of content. They are 'social facts' manufactured in certain circumstances, contexts or social settings. They not only describe an event in a neutral way, but also help to create it; they are 'acts of persuasion'

(Coffey, 2013: 372) which seek to accomplish specific goals (Bryman, 2016). The research presented here was concerned with the role of interests, values and professional ideologies in the publicly expressed testimonies of different actors in regard to the regulation of CAM. It also concerned itself with ambiguities and inconsistencies in these actors' testimonies in order to capture any changes in their views on CAM regulation. This means that we should take into account the language and discourse employed by social institutions and actors over time. Therefore, the first author adopted a 'sceptical reading' (Gill, 2000) and looked at the vocabulary, phrases and discourse of agents as rhetorical devices for acquiring an authoritative voice.

This method is usually referred to as critical discourse analysis, which searches for a purpose behind the manner in which something is said and seeks to understand how discourse is implicated in relations of power. As Bryman (2016: 534) puts it: 'discourse is a way of constituting a particular view of social reality. ... [And so] choices are made regarding the most appropriate way of presenting it'. For example, one way of uncovering hidden interests, values and ideologies in the discourses and language used in CAM regulation was by paying particular attention to opposing and contrasting ideas and the varied names used for CAM therapies in the documents over time, as shown in the findings section. Furthermore, since the authors looked at discourse as a source of power, Light's countervailing power theory was shown to be an appropriate framework for guiding the analysis. The first author analysed the documentary data by hand.

2.3. Ethics

Ethical approval for this research study was obtained from the Ethics Committee of the Centre for Criminology and Sociology, Royal Holloway, University of London. Particular

attention was paid to the credibility, authenticity and representativeness of the documentary data.

2.4. Terminology

In this research, CAM refers to a broad set of healthcare practices that are not part of a country's own tradition (WHO, 2001: 1). 'Orthodox medicine', in turn, is used interchangeably with 'biomedicine' and refers to institutionalised medicine grounded in scientific logic and an evidence-based ethos which has political legitimacy (Saks, 2003).

We now turn to the presentation of the main findings on the history of the regulatory process of CAM in Portugal.

3. The process of CAM legislation in Portugal

Portugal became a semi-presidential democracy following the transition from a dictatorship in 1974 to the proclamation of the new Constitution in 1976 (Neto & Lobo, 2012). The country's semi-presidential regime is legitimised, according to Neto and Lobo (2012), through the power of the Portuguese President in the political process. The President shares considerable influence with parliament which s/he can dissolve and whose legislation s/he can veto.

The Portuguese central government, through the Ministry of Health, is responsible for developing, overseeing, evaluating and implementing health policy, whether it is related to public (National Health Service) or private healthcare (Barros et al., 2011). The Ministry of Health contains several departments, including the Directorate-General of Health (DGS), a key department concerned with health policy-making, regulation and supervision of healthcare activities, institutions and services in the country (Barros et al., 2011).

3.1. State support for CAM legislation in the late 1990s

The new CAM legislation in Portugal is the result of an unprecedented increase in governmental interest in CAM since 1996. Table 1 shows the sequence of main events from 1996 to September 1999. These events show evidence of a change in the relationship between the Portuguese state and CAM.

Table 1. Timeline of the first political moves in relation to CAM legislation in Portugal

16th April 1996	A working group on CAM legislation is set up under the remit of the DGS
16th March 1999	The DGS's working group submits a CAM report to the DGS
29th July 1999	A proposed Draft on the Medical Act is approved by the Council of Ministers
24th September 1999	The proposed Draft on the Medical Act is vetoed by the President of the Republic

In 1996 a report on the legal status of CAM worldwide and in Portugal in particular was produced by a working group made up of representatives appointed by the Ministry of Health. In March 1999, under the left-of-centre Socialist Party's government with António Guterres as Prime Minister, the DGS published this report. The publication of this report was very controversial and deserves to be explored in more detail. Although the report mentions the National Federation of Natural Alternative Medicine's Associations (FENAMAN), an umbrella body for CAM associations in Portugal, as the main proponent of setting up the aforementioned working group on CAM, the latter group was only formed of representatives of the DGS, the Medical and the Pharmaceutical Councils, the Directorate-General of Higher Education, and the Department of Human Resources for Health, thus excluding any CAM representatives.

The DGS report on CAM represents the beginning of CAM regulation in Portugal in a variety of ways. First, it embraces a public health policy agenda by stating the need to explore other 'knowledge areas' in health besides the one propounded by biomedicine, areas which can be

either complementary or alternative to conventional medicine. The report identifies five CAM therapies: acupuncture, homeopathy, osteopathy, chiropractic and phytotherapy. Second, the report is sympathetic to the professionalisation of CAM practitioners, pointing to the need for CAM credentialism and for an appropriate CAM curriculum to combat fragmentation and achieve greater cohesion. Third, the report mentions the crucial role of the state in the successful integration of CAM into mainstream healthcare and the protection of individuals' health. As the report states:

> There was an overall agreement among the members of the working group that the quality of CAM education should be raised through the setting up of high standard courses and through the accreditation of those professionals with appropriate credentials. Therefore, an attempt to regulate these [CAM] therapies by statute should be undertaken, in order to fight against the current anarchy [in CAM's practice] (DGS, 1999: 41-42).

Finally, the report calls for the setting up of a committee with representatives of the Ministry of Health, the Ministry of Education, the Medical and Pharmaceutical Councils, and CAM associations, which should be tasked with drawing up statutory regulation for CAM and CAM practitioners (DGS, 1999).

Not surprisingly, this report was well received by the representatives of CAM associations, as it was in line with CAM's interests. Nevertheless, criticism of the 'scandalous lack of CAM representatives' (O Dia, 1999: 11) within the working group was evident.

Meanwhile, the Portuguese Medical Council (Ordem dos Médicos) (PMC) tried to persuade the state to reject the government's proposal for CAM regulation, without success. As the DGS report itself discloses, most of the working group's meetings were held '… without the presence of all the appointees due to a variety of reasons, and some of the appointees were

substituted by others' (DGS, 1999: 4). In the end, all the appointees agreed and subscribed to the report, apart from the PMC's representative, who disagreed with its proposal for CAM regulation. As Germano de Sousa, the PMC's chairman at the time, stated in an interview released by the newspaper *Primeiro de Janeiro* in July 1999:

> We [the PMC] will assess it [the DGS report] in due course but I believe that any conclusive evaluation [of the report] is far from being achieved. … Specifically, the big concern here is the need to protect Portuguese citizens from the manoeuvring of groups [CAM] without any scientific basis to treat diseases ... In other words, the money currently spent on health is precious and so cannot be wasted on [CAM] practices which are not scientifically proven. There are some 'laboratories' which manufacture so-called homeopathic drugs but the latter are just water which have been sold like gold (Bessa, 1999: 5).

This statement makes evident the reasons for the PMC's rejection of the DGS report, with specific reference to homeopathic drugs. The disparaging way in which the PMC dismissed CAM and CAM practitioners on the grounds of lack of scientific evidence for their treatments is noteworthy. This act of challenging state support for CAM legislation was accompanied by the PMC's submission to the government in July 1999 of a proposed Draft of the Medical Act, requiring that everyone performing medical acts must be registered with the PMC.

This Draft provided the basis of discord between the government and the medical profession. Although approved by the Council of Ministers, the Draft was vetoed by Jorge Sampaio, the President of the Republic, who pronounced it unconstitutional to impose restrictions on who could treat patients.

So one can see that, by the end of 1999, the DGS report and the presidential veto nurtured CAM interests and resisted the medical profession's attempts to retain its power by trying to legislate on who could provide health services. These events provide evidence of a change in the relationship between the Portuguese state and CAM. Furthermore, the support of the DGS, a state institution, and the countervailing power of CAM practitioners, created favourable conditions for the first major political attempt to regulate CAM by statute. This took place at the end of 1999, as we will see next.

3.2. The first attempt at CAM regulation

A brief description of the Portuguese parliamentary process is essential in order to understand the regulation of CAM in the country. Four political parties have dominated the Parliament: the left-of-centre Socialist Party (PS); the right-of-centre Social-Democratic Party (PSD); the left-wing Communist Party (PCP), and the right-of-centre Democratic and Social Centre – People's Party (CDS-PP). Other parties with a smaller share of seats in parliament are the left-wing Ecologist Party, 'The Greens' (PEV), and the Left wing Bloc (BE). The Left Bloc party is one of the youngest parties, with nineteen MPs in parliament out of 230 in 2015, and is popular for its proposals on controversial issues such as domestic violence and abortion, women's and gay rights, immigration, genetically modified food, and CAM regulation.

Table 2. Timeline of the first attempt at CAM legislation

7th December 1999	The Left Bloc Party (BE) submits a CAM Bill (*Projeto de Lei nº 34/VII – Regulamentação das Medicinas não Convencionais*)
25th October 2000	The Socialist Party (PS) submits a CAM Bill (*Projeto de Lei nº 320/VIII – Lei do Enquadramento Base das Medicinas não Convencionais*)
July 2001	The PMC presents its official position on the BE and PS Bills on CAM legislation by submitting a report to the *Commission of Health and Drugs*
August 2001	The Portuguese Medical Society of Acupuncture is founded
January 2002	Prime Minister António Guterres resigns and parliament is dissolved
4th April 2002	The BE and the PS Bills expire

The Left Bloc Party was the first party to submit a CAM Bill to parliament in December 1999 (Projeto de Lei nº 34/VII). Nearly one year later, in October 2000, the Socialist Party, the dominant left-of-centre party, also submitted a CAM Bill to parliament (Projeto de Lei nº 320/VIII). Both Bills claimed that there was an urgent need to begin the national statutory regulation of CAM. The main arguments in both documents were: lay use of CAM has increased in many Western countries including Portugal; the need for CAM regulation has become a reality; medical interest in CAM has risen; and therapeutic pluralism has become increasingly popular.

As one can see, both Bills embraced 'upstream' public health interventions (Hunter, 2003), by stimulating policy change through CAM regulation. Submission of CAM bills by both the BE and the PS was thus suggestive of a strategic alignment with CAM's interests.

Meanwhile, in an interview for the Portuguese TSF radio station (18/10/2000), Germano de Sousa, the PMC's chairman, dismissed the PS Bill on CAM regulation by saying that it was 'completely unnecessary' and admitted ironically to not understanding the rush towards the regulation of CAM since there were '… many other issues that the parliament should be concerned about'.

In 2001, the PMC presented its official position on the BE and PS Bills on CAM regulation by submitting a report (SRNOM, 2001) to the Parliamentary Committee on Health and Drugs. The report outlined the PMC's position on the Bills as follows:

(1) The use of the term 'non-conventional medicines' was advocated. According to the report (SRNOM, 2001: 51), '… there is only one medicine and the efficacy of any self-proclaimed non-conventional therapy, once scientifically proven, will be incorporated immediately into the medical canon'. The PMC proposes therefore to apply the term 'complementary

therapeutics' to these therapies;

(2) Representatives from the Ministry of Health, the Ministry of Education and the PMC and from each CAM therapy should be included in the technical committee. Furthermore, CAM representatives should be individuals with recognised merit within their therapy and should have CAM accreditation by the European Union;

(3) Neither Bill makes a clear distinction between those therapies backed by scientific evidence and those which lack any scientific basis, referred to as 'quackery'; only acupuncture, osteopathy and chiropractic should be regulated, since these are the only ones supported by scientific evidence for specific medical conditions;

(4) The process of diagnosis and prescribing should be under medical jurisdiction, and clinical autonomy should not be accorded to CAM practitioners;

(5) Only medical doctors should refer patients to CAM practitioners where appropriate, while the latter should be aware of the limitations of their practice. In cases of acute illness, for example, CAM practitioners should immediately refer patients to scientific medicine;

(6) Finally, CAM practitioners should not be allowed to manufacture any products or instruments prescribed or used for therapeutic purposes.

Although the PMC had traditionally rejected CAM, this last report indicates the endorsement of 'CAM poaching' (Boon et al., 2004), i.e. the incorporation of 'the 'best' or 'scientifically proven' CAM treatments within the jurisdiction of medicine in a bid to eliminate the need for CAM practitioners (Boon et al., 2004: 129). For example, CAM therapies are redefined as 'complementary therapeutics', in contrast to the WHO's recommended term 'complementary and alternative medicine'. Furthermore, acupuncture, osteopathy and chiropractic are acknowledged by the PMC report as CAM modalities deserving recognition due to their basis

in scientific evidence for certain treatments. Scientific evidence is therefore used in this report to legitimise some aspects of CAM. Having established their scientific credentials, CAM modalities are expected to transform themselves into 'just one more therapeutic resource' which can then be incorporated into the biomedical canon (Boon et al., 2004).

Furthermore, the report can be seen as an attempt to protect established medical practices, such as diagnosis and prescribing, by advocating that these practices should remain under the authority of orthodox medicine. Finally, the report shows that the Council has moved from refusing to be involved in a future CAM Committee to a more conciliatory position, in which they would participate alongside representatives of mainstream healthcare and the six CAM modalities.

This 2001 medical report therefore reflected the strategy chosen by the elite of the medical profession to counteract governmental interest in CAM. It involves an attempt to move from a position of rejection to one of 'incorporating' CAM (Saks, 1995), by opening the door to some of CAM's 'scientifically based' therapies, namely acupuncture, osteopathy and chiropractic. Also, the claims presented in this medical report appear to have impacted on the new CAM legislation itself, as we will show subsequently. Finally, the PMC report was followed by the foundation of the Portuguese Medical Society of Acupuncture in August 2001, which was charged with preparing a proposal for a medical competency in 'medical acupuncture'.

However, neither the BE nor the PS Bill on CAM gained final approval. In January 2002, following a disastrous result for the Socialist Party in the local elections, Prime Minister António Guterres resigned and so did the government. In such a politically unstable climate, achieving a parliamentary consensus on 'marginal' issues such as CAM regulation was unlikely and in April 2002 both Bills expired.

One can see here the countervailing divisions emerging within the Portuguese state itself, as represented by the political parties. In an interview for TSF radio (7/01/2002), the BE Party's leader Francisco Louçã mentioned the close partnership between the right-of-centre Social-Democratic Party and the PMC on this matter, who he claimed 'were lobbying the regulators [not to support CAM regulation]' and also neglecting 'patients' rights in favour of business'. The Social-Democratic Party was even accused by Louçã of taking advantage of political instability in the country by lobbying MPs to vote against this move.

In summary, the first attempt at CAM regulation in Portugal failed as a result of the use of countervailing powers by the political parties at a time of short-lived political instability. We will now turn to the analysis of the second attempt at CAM legislation.

3.3. The second attempt at CAM regulation

Table 3. Timeline of the second attempt at CAM legislation in Portugal

21st May 2002	The Left Bloc Party submits a new CAM Bill (Projeto de Lei nº 27/IX – *Regime Jurídico das Terapêuticas não Convencionais*)
May 2002	Acupuncture is recognised by the PMC as a 'medical competency'
18th March 2003	The Socialist Party (PS) submits a new CAM Bill (Projeto de Lei nº 263/IX – *Lei do Enquadramento Base das Medicinas não Convencionais*)
15th July 2003	The Portuguese parliament passes a new Act (nº 45/2003 – *Lei do Enquadramento Base das Terapêuticas não Convencionais*)
22nd August 2003	The Act nº 45/2003 is issued in the Diary of the Republic

In April 2002, following Guterres' resignation, the right-of-centre PSD Party fought and won the general election under the leadership of Durão Barroso. The following month the Left Bloc Party re-introduced the debate on CAM regulation by submitting a new Bill, which was largely based on the previous one (Projeto de Lei nº 27/IX). This revived Bill reinforced the need for CAM regulation by drawing on the WHO's reports on CAM. It also contained conceptual developments such as replacement of the word 'medicines' with the word 'therapeutics' in the title. Meanwhile, in the same month (May 2002), the PMC approved the

grounds for a proposal for a competency in 'medical acupuncture' for medical doctors, submitted by the recently created Portuguese Medical Society of Acupuncture.

Almost one year later, in March 2003, the PS Party also introduced a new Bill on CAM regulation to Parliament, which was similar to its previous submission (Projeto de Lei nº 263/IX). In June 2003 a reviewed and combined text of these two documents was debated and voted for unanimously by all MPs. The next stage was the creation of a Decree, its endorsement, and the drafting of a new Act 45/2003.

In sum, the second attempt at CAM legislation and its successful outcome, with the creation of the new Act, was undertaken over a very short period and suggests a convergence of the positions of the different political parties regarding CAM legislation. In this sense, this second attempt helped to solidify the allegiances between the political parties, the state and CAM and demonstrates a clear shift in the state's position towards CAM. We will now turn to the analysis of the content of the new Act 45/2003.

3.4. The content of Act 45/2003

This new Act put six CAM therapies on the road to statutory regulation. It contains some important aspects that are worth mentioning. First, it reflects the influence of the PMC. For example, the new Act suggests a new and specific socio-political concept – 'non-conventional therapeutics' – discarding the use of the term 'medicine'. This new term has become commonplace within CAM political and professional circles since 2003 and is applied to those therapeutics which '… depart on different philosophical grounds from conventional medicine and use specific processes of diagnosis as well as their own therapies' (ARP, 2003:5391).

The definition of 'non-conventional therapeutics' is legitimated in the Act by referring to the

reports of the WHO on CAM. By drawing on the WHO's definition of CAM, this new Act appears to demarcate CAM from conventional medicine as well as to encourage CAM's occupational closure. For example, this CAM definition legitimates CAM therapies as different from biomedicine and as having professional autonomy from the medical profession. However, despite this aspect favourable to CAM, the document emphasises the importance of ethical standards for CAM, some of which were influenced by the PMC's earlier claims, such as the promotion of scientific evidence-based research as a way to achieve higher quality, efficacy and effectiveness.

The Act still states that only professionals holding legal and accredited qualifications can practise CAM. However, unlike the PMC's position, this new Act also recognises the clinical autonomy of CAM practitioners. Therefore, the potential subordination of CAM to the medical profession is not explicitly contemplated in the new CAM legislation. Despite being in favour of CAM, this specific clause on CAM's clinical autonomy has turned CAM legislation into a much longer and messier process, as the autonomy of CAM practitioners remains a controversial issue within medical orthodoxy.

With the creation of the new Act 45/2003, a committee charged with CAM regulation was set up. We now turn to a more detailed look at this committee.

3.5. The ad hoc committee on CAM legislation

There are two kinds of parliamentary committee in Portuguese government: standing committees, which are specialised committees with permanent jurisdiction over specific matters; and ad hoc committees, established for a limited period of time and charged with a specific function which usually culminates in the presentation of a report. Parliamentary committees and their scope are defined by the Assembly of the Republic and their members

472 are appointed by all the Parliamentary groups (in accordance with their proportional share of
473 seats in the Assembly).

474 In May 2004, a new ad hoc Committee (CTCTNC) was tasked with regulating CAM. The
475 dynamics within this new Committee and the timeline of the governmental and political
476 actions in relation to it are worth noting.

477 **Table 4: Timeline of the governmental and political actions of the ad hoc Committee on CAM**

28th May 2004	An ad hoc Committee is set up and tasked with regulating CAM (Despacho Conjunto nº 327/2004)
December 2007	The Committee hands in its proposals on CAM regulation to the DGS
June/July 2008	Public discussion of the Committee's proposals on CAM regulation takes place
31st December 2008	The material from the public discussion is sent to the Committee which is charged with writing a final report
17th October 2009	The Left Bloc Party (BE) submits Query nº 299/XI/1 to the Ministry of Health
22nd April 2010	The Ministry of Health replies to the BE's Query nº 299/XI/1
29th July 2011	The BE submits a Resolution Project (Projecto de Resolução nº 42/XII/1ª)
9th November 2011	The Assembly of the Republic publishes Resolution 146/2011, advising the government to complete the process of regulating CAM

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479 This ad hoc Committee on CAM initially comprised 16 members who were appointed by the
480 DGS: six CAM representatives, seven healthcare professionals and academics recognised by
481 the state, and three representatives of government. It took around four years for the public
482 discussion of the Committee's proposals on CAM regulation to be completed. The
483 Committee witnessed the withdrawal of some conventional healthcare appointees, as well as
484 several disagreements among CAM representatives and CAM associations. This showed not
485 only signs of fragmentation within CAM, but also internal divisions within the state.

486 In October 2009, the Left Bloc Party (BE) pressurised the Ministry of Health by asking about
487 the date for publishing the post-public discussion report on CAM regulation and the
488 implementation of Act 45/2003. In July 2011, the BE submitted a Resolution Project to

parliament, recommending the implementation of Act 45/2003 (Projeto de Resolução nº 42/XII/1ª). This document emphasised the long delay in CAM regulation in Portugal (at the time, eight years had passed since the enactment of Act 45/2003) as well as the absence of the ad hoc Committee's chairman, who had resigned. This Resolution Project was approved and published by the Assembly of the Republic, which advised the government to complete the process of CAM regulation.

Meanwhile, the PMC opened itself up to homeopathy, by hosting in March 2012 at its headquarters the first seminar for scientific research in homeopathy, organised by the Homeopathic Society of Portugal. The latter had been founded in 2003 by a small group of medical doctors and pharmacists who defined homeopathy as a 'medical approach'.

It took almost one year from the approval of the BE's Resolution for the government to take action on regulation of CAM, as we will see next.

3.6. The replacement of Act 45/2003 by Act 71/2013

Table 5. The main governmental and political activities between 2012 and 2014

22nd November 2012	The DGS presents a Bill on CAM to the Committee (Proposta de Lei 111/XII)
2nd September 2013	The Act nº 71/2013 is listed in the Diary of the Republic
3rd February 2014	The competencies of a second ad hoc Committee are established (Portaria nº 25/2014)

At the end of 2012, the government announced a Bill proposing regulation of CAM (DGS, 2012), and made clear the need for the creation of professional credentials for CAM practitioners as well as the online registration of credentialed practitioners in the country, under the remit of The Central Administration of the Health System (ACSS), a public institution supervised by the Ministry of Health (TSF, 1/02/2012). Furthermore, this Bill clearly states that CAM professionals cannot claim that their actions are curative. The announcement of the Bill was subject to many criticisms by the CAM community, which

argued that it ignored the work done over the years by the ad hoc Committee and usurped the Committee's right to regulate CAM.

The main aim of this CAM Bill was to update and regulate Act 45/2003. It was debated in parliament and voted for by the PSD, the PS and the CDS-PP parties, with abstentions from the BE, the PCP and the PEV parties. In September 2013, a new Act 71/2013 was created. Unsurprisingly, a new ad hoc Committee was created under the new Act which superseded its predecessor. Finally, Traditional Chinese Medicine was added to the list of CAM therapies to be included in the legislation. This last aspect amazed the PMC, who, in a letter to the President of the Republic, Aníbal Cavaco Silva, declared that they had not been consulted about this therapy '... which was included at last minute, quietly, in the [DGS] Bill 111/XII, to avoid the danger of rejection' (PMC, 2013: 36). Again, the main objection of the PMC to the inclusion of Traditional Chinese Medicine concerned its terminology, with the PMC proposing it should be replaced by 'Traditional Chinese Therapies'. This proposal was refused by the government and the terminology 'Traditional Chinese Medicine' remained in the Bill.

3.7. A higher education degree in CAM

In October 2014, the government published the competencies set up by the ad hoc Committee for the seven CAM therapies included in the Act 71/2013. More recently, in June 2015, the government published the educational standards of five out of the seven therapies included in the new Act. These documents recognise acupuncture, osteopathy, chiropractic, phytotherapy and naturopathy – thus excluding homeopathy and traditional Chinese medicine – as CAM therapies and set the educational standards for becoming a CAM professional, which involve completion of a four year higher education degree.

Table 6. The main governmental and political activities between 2014 and 2015

8th October 2014	The competencies of CAM are 'set up' (Portarias nº 207-A, B, C, D, E, F, G/2014)
5th June 2015	The educational standards for acupuncture, osteopathy, chiropractic, phytotherapy and naturopathy are established (Portarias nº 172-B, C, D, E, F/2015)

4. Discussion

This paper has explored (1) the extent to which CAM practitioners have influenced policy-making in Portugal and thus acted as a countervailing power; (2) the degree to which the Portuguese political system has sustained CAM practitioners' attempts to be included in orthodox healthcare; and (3) changes in the medical profession's position towards CAM and CAM practitioners.

We started by depicting the role of the government as having sown the seeds of CAM regulation in the late 1990s through publication of a report showing the need for CAM legislation, following pressure from FENAMAN. This governmental action encouraged unprecedented political interest in and contestation over CAM statutory regulation, and provoked countervailing actions from the political parties, the medical profession and CAM. The findings outlined here suggest that these countervailing actions resulted in the creation of Act 45/2003 which regulated six CAM therapies, later replaced by Act 71/2013, which updated the former and regulated seven CAM therapies. By creating these Acts, the Portuguese state has shown itself to be sympathetic to CAM legitimacy, indicating that CAM's relationship with the state has clearly changed.

CAM practitioners have acted as a source of power and a countervailing force in relation to the medical profession and the state, in that they have demonstrated significant influence on the policy-making process. The New Act 71/2013, although calling for a scientific model of CAM, is sympathetic to CAM practitioners. It has legitimised CAM's quest for professional

autonomy as long as it complies with the standards of a 'profession' by seeking professionalisation, and has not restricted the practice of CAM to the medical profession, as the latter wished. Furthermore, if this statutory regulation is completed in the near future, Portugal will be at the forefront of CAM regulation in comparison with other Western countries.

At the same time, the medical establishment's reaction to CAM's attempts at statutory regulation has changed. At the end of the 1990s, the PMC at first resisted CAM practitioners' attempts to promote the issue of CAM through the political system, on the grounds that CAM lacked a basis in scientific evidence. In 2001, the Medical Council changed tack and attempted to exert its 'biomedical gaze' over CAM legislation, despite its generally hostile position on such legislation. It published a report advocating the incorporation of 'scientifically proven' CAM therapies within medicine. In 2002 it accepted acupuncture as a 'medical competency' and has increasingly addressed homeopathic practice among medical doctors. Overall, the medical establishment's relationship with CAM has changed, moving from rejecting all CAM therapies to incorporating selected ones, thus following countries such as the UK (Saks, 1995), the USA (Baer, 2004), Canada (Kelner et al., 2004) and New Zealand (Dew, 2000). In the same manner as observed by Saks (1998) in relation to British society in the late 1990s, it can be argued that in 21st-century Portuguese society the medical profession has maintained professional dominance and authority through incorporation of CAM.

The PMC has also acted as a site of power and has influenced state policy-making. First, its claims to ownership of the word 'medicine' impacted on the government's wording of the new CAM Bill, which was changed from 'CAM' to 'non-conventional therapeutics'. This adopted term differs significantly from the terms used by supra-state organisations such as the WHO and the *Council of Europe*, in which 'complementary and alternative medicine'

prevails. This is suggestive of the symbolic power of language to achieve political goals and thus occupational closure. Second, the creation of the first ad hoc Committee to regulate CAM followed the advice of the PMC, giving the latter the opportunity to exert a 'biomedical gaze' and thus control over the Committee, with seven out of thirteen appointees of the Committee comprising conventional healthcare representatives. Finally, the new Act 71/2013 adopted the rhetoric of biomedicine by stressing the need for a scientific evidence base for CAM. More recently, in 2015, the government published the educational standards for five out of seven CAM therapies, excluding homeopathy and traditional Chinese medicine from this process. Homeopathy was ruled out because of the lack of evidence of its efficacy, while traditional Chinese medicine was omitted because of the use of the word 'medicine' in its name. So, in Portugal, the medical profession has been strong enough to persuade the state to pay some attention to its interests, and thus to maintain biomedical dominance and the status of orthodox medicine within mainstream healthcare.

Accordingly, the Portuguese government has been in a challenging position in which it must mediate between implementing guidelines formulated by supranational agencies such as the WHO, which appear sympathetic to the integration of CAM and CAM practitioners in mainstream healthcare worldwide; biomedicine's resistance and traditional dominance; and the counteractions of CAM. It has tried to accommodate the interests of both the medical profession and CAM in an attempt to maintain its traditional relationship with the medical profession whilst simultaneously showing signs of openness to CAM. This has also been the case in other states, such as the USA (Goldstein, 2002), Australia (Baer, 2006), Britain (Saks, 1995) and Canada (Kelner et al., 2004).

It has furthermore been shown that the Portuguese state is itself a constellation of countervailing forces with different goals and priorities (Light, 2010). The working group on CAM legislation set up under the remit of the DGS in the late 1990s never worked efficiently

608 due to internal disagreements between appointees. Certain political parties forged alliances
609 with CAM, while others supported the medical profession and the hegemony of the
610 biomedical model in healthcare, thus creating divisions within the state itself. The work of the
611 first ad hoc Committee to regulate CAM took place over two years due to disagreements
612 among members who ended by resigning and abandoning the group. Subsequently, the
613 government announced a new Bill in place of Act 45/2003, thus imposing its power and its
614 own vision of CAM legislation (Greenberg, 1990).

615 Above all, the Portuguese state has acted as a broker (Dunleavy and O'Leary, 1987), which,
616 although constrained by the interests of the medical profession and CAM and by internal
617 countervailing forces, has demonstrated its traditional autonomy and regulatory power. The
618 recent announcement by the government of the new Act 71/2013, and its subsequent approval
619 by parliament, clearly demonstrate the legislative authority of the state as well as its
620 regulatory role in shaping health policy-making in Portugal. The power of the Portuguese
621 state can also be seen in the current delay in CAM regulation inasmuch as, at the time of
622 writing, the most recent CAM regulation is still underway and CAM professionals remain
623 marginalised in Portuguese healthcare.

624 The research reported here has looked at CAM practitioners collectively as a major player
625 which has organised against medical dominance in order to rearrange power relations and
626 reshape healthcare markets. The establishment of strategic alliances between CAM
627 practitioners and the state over time and the consequent balance of power between these two
628 actors and the medical profession, with the inclusion of CAM legislation in the political
629 agenda, has been evident. Yet it was also evident that biomedical power remains extremely
630 important in terms of providing directions for the regulation of CAM in Portugal.
631 Nevertheless, by using countervailing power theory to analyse CAM's relationship with key
632 actors in the healthcare sector, the study presented here has highlighted the dynamic nature of

social relations in this area. For CAM practitioners, the medical profession and the state have negotiated to influence Portuguese healthcare, acting as sources of countervailing power. This process has involved simultaneously opposing and allying with each other. Consequently, the medical profession, although maintaining its power and status, may be losing its hegemonic and corporatist control over CAM legislation in the country.

Above all, the research reported here has demonstrated the need to move away from both the professional dominance and the corporatist approach to healthcare and to adopt a hybrid countervailing power framework in order to better understand developments in CAM's status and legislative change in Portugal. Future research needs to be conducted on the extent to which the regulatory role of the Portuguese state differs from that of other Western states in terms of CAM legislation. In the same vein, research is needed on how the medical profession in other Western countries views CAM legislation in comparison with its position in Portugal and the role of supranational bargaining in CAM regulation in these countries.

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