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The professionalisation of aromatherapy: a case study of the professionalisation of complementary and alternative medicine in the Australian health care system

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The Professionalisation of Aromatherapy:

**A case study of the
professionalisation of complementary and alternative medicine
in the Australian health care system.**

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Submitted at Southern Cross University, Lismore
Submitted For Doctor of Philosophy (Health Care)
Submitted in September 2006

I certify that the work presented in this thesis is, to the best of my knowledge and belief, original, except as acknowledged in the text, and that the material has not been submitted, either in whole or in part, for a degree at this or any other university.

I acknowledge that I have read and understood the University's rules, requirements, procedures and policy relating to my higher degree research award and to my thesis.

I certify that I have complied
with the rules, requirements, procedures and policy of the University (as they may be from time to time).

Signed.....

Returning the Heart to Health Care

(A subtitle)

'You are making a mistake. Do you not see the logic of my plans.'

'Yes, but it just seems too, heartless.'

'My logic is undeniable.'

From I, Robot Producer John Davis

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Abstract

The aim of this study was to examine aromatherapy practice in relation to its claim of being or becoming a profession. This process of professionalisation is explored within the current context where the status of complementary and alternative medicines within the Australian health care system, like aromatherapy practice, is currently influenced by medical dominance and broader social and political scrutiny. This investigation of aromatherapy practice may provide a model for the general professionalisation, or development, of complementary and alternative medicine in Australian health care today.

Critical theory was employed as the primary methodology of this study. As critical theory has no defined method for data collection, grounded theory data collection and analysis methods were used to obtain current and relevant data from two of the most prominent users of aromatherapy practice in health care, aromatherapists and nurses.

The study found that while aromatherapy is often referred to as a profession, it fails to meet the criteria for being considered a profession in the 'true' sense. The data also revealed felt dissatisfactions experienced by aromatherapists' to be due to the lack of recognition of the practice and a perceived double bind regarding the need to establish an appropriate knowledge base via scientific research and maintaining the 'essence' of aromatherapy practice. Considering the professionalisation process and the requirements of the system (health care and Government) a number of potential pathways for the development of aromatherapy practice were explored. The findings and discussion have relevance to other complementary and alternative modalities endeavouring to professionalise and or increase their status within the Australian health care system. In addition the study considers the related public felt dissatisfaction and revealed false consciousness relating to a broader social change and the integration of holistic and biomedical practices in health care.

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Introduction

So long as the tools a paradigm supplies continues to prove capable of solving the problems it defines, science moves fastest and penetrates most deeply through confident employment of those tools. The reason is clear. As in manufacture so in science-retooling is an extravagance to be reserved for the occasion that demands it. The significance of crisis is the indication they provide that an occasion for retooling has arrived.

Kuhn, 1962

This study evolved from the quest to investigate aromatherapy practice as a profession. Aromatherapy practice has been referred to as an ‘emerging profession’ (Harris, 2002), ‘the aromatherapy profession’ (Kirk-Smith, 2002) and ‘our profession’ (Thorne, 2002). From these statements it could be implied that aromatherapy is well on the way toward becoming a profession, if not being one. Alternatively the situation may be a reflection of Johnson’s (1972) words ‘it is assumed that the claim of professional status are themselves *the* major conditions for professionalisation.’

In investigating aromatherapy practice as a profession it is important to note that professionalisation occurs within a social context. Thus for a health care modality such as aromatherapy practice what ‘health care’ and ‘professions’ ‘are’ and ‘do’ are significant considerations. Consequently to address the issue of aromatherapy as a profession and its professionalisation it is necessary to be cognisant with what is required of a profession in health care and how to professionalise. That is, to understand the systems that aromatherapy is attempting to work within. Further it is essential to look at issues of the process of professionalisation. For example, it is important to note that what ‘health care’ and a ‘profession’ are conceived to be changes over time and context, as does ‘aromatherapy practice’.

An important issue for the professionalisation of aromatherapy practice is the current demand by the people of Australia for ‘complementary and alternative medicine’ (CAM). This is observed in the increased demand for health care practices that are not part of the dominant biomedical system. By placing the process of professionalisation of aromatherapy practice into the current context of ‘demand for’ and ‘integration of’ CAM into the health care system the study rapidly evolved into the ‘development of CAM in Australian health care,’ with aromatherapy practice as a case study. As a result this thesis is not only a study of the potential development of aromatherapy practice but also about the professionalisation of CAM within Australian health care. As a consequence Chapters One and Two explore health care, the growth of CAM in Australia and the Government’s role in the professionalisation of health care practices.

For this thesis the very broad term ‘complementary and alternative medicine’ (CAM) is used to refer to any and all health care practices that are not within the established ‘mainstream’ health care system today. I do not distinguish between those that have begun

the integration process and those that have not. CAM practices are interchangeable known as natural therapies, alternative therapies and complementary therapies and include such diverse practices as vitamin supplements, crystal healing, laying of hands, as well as aromatherapy, acupuncture, and chiropractics. According to Weisner (1995) the terms alternative, natural, complementary or holistic medicine describe the same entity. However each term has specific meanings. The appropriate use of each term is not an issue of the specific domain of this study. The exception being for the term 'holistic,' which will be covered when considering two broad approaches to health care in Chapter One. The use of the very broad term 'CAM' in this study is not because I think all the practices are the same but rather because despite the wide diversity in the practices issues of professionalisation and or integration into the health care system are largely the same for them all, and it is this process that is the focus of the study.

The overall goal of the thesis is to look at the process of professionalisation related to CAM in general and aromatherapy in particular. To build on the historical development and context setting begun in Chapter One and Two, Chapter Three considers the development and current standing of aromatherapy practice. Chapter Four and Five address professions and the professionalisation process. These chapters provide the background for Chapter Eleven's discussion on the professionalisation pathways for aromatherapy and the most likely pathway for aromatherapy's development, as emerged from the study. For this knowledge, on the professionalisation of aromatherapy practice and other CAM in Australian health care, to be of pragmatic value it is necessary to overcome any resistance from aromatherapists and other CAM practitioners which brings us to the study proper.

It is important that you the reader know the framework from which the information for the study was collected and utilised, that is the methodology and method of the study. Chapter Six provides an overview of the methodology and Seven the method. This study considers the historical development and potential future of aromatherapy practice and health care. The intention is to empower aromatherapists as members of an occupation to make informed choices for the future of the practice in the Australian health care system, its professionalisation. With this intention the study best fits the critical theory framework.

From investigating 'aromatherapy a profession,' philosophical difference emerged as a foundational issue for all health care practices, and professions alike. Consequently the

study considers the oppression of the holistic principles of health care by the biomedical approach. While this maybe considered an obvious or outdated argument (with the introduction of body mind therapies) it will be argued that the philosophical differences between the two approaches are generally confused and as a consequence a critical issue for the development of CAM practices and Australian health care alike. By clearly considering the issue of philosophical differences a more significant and pervasive theory of oppression in health care is revealed.

Due to the combination of the initial intention and revealed issue this thesis operates on two levels: the level of the practical process of professionalisation of aromatherapy discussed in Chapter Eleven as a case study for the development of CAM in the health care setting and; the philosophical underpinnings of the health care practices and the impact that has on the process of professionalisation and indeed the development of Australian health care which is discussed in Chapter Twelve.

Whilst it is hoped that the information from the study will be utilised by aromatherapy practice and other CAM occupations, considering professionalisation, it is the implications of the emerged issue that has the potential of far reaching application. Consequently this thesis has the potential to impact on the current changes in health care services, as well as the development of aromatherapy and other CAM practices. Further it also has the potential to influence the development of professions for the theory that emerged relates to a core issue that is raised regarding current considerations for a 'new profession' for the 21st century as noted in Chapter Four. However, above all else this thesis calls for

'returning the heart to health care'.

Part One

Historical Background and Context Setting

*Indeed one of the firsts tasks of any new discipline is the
construction of a history which will explain the
inevitability of its arrival, justify its existence and promote its future.*
Kuhn, 1962

Chapter 1

Health, Health Care and Natural Therapy Growth in Australia

At the turn of the twenty-first century, the human is no longer seen as a sophisticated machine, a computer, or a box of drives, but as a creature that combines within itself both yin and yang, body and mind, stress and hope

Jacoby, 2003

This chapter presents an overview of the historical background of health care directly related to the integration of complementary and alternative medicine (CAM) into the dominant biomedical health care system. This is important for the study as it clarifies the context within which aromatherapy is to professionalise and provides a historical understanding of that context. Consequently, this chapter briefly outlines health and health care focusing on the holistic, which CAM is routinely associated with, and the analytic approaches. The importance of distinguishing between the two approaches is noted. Then the chapter will proceed to a contracted outline of the development of biomedical health care and expressed dissatisfaction with it. Finally the recent growth in demand for CAM and biomedicine's conditional acceptance of it will be considered.

I Health and Health Care

Broadly speaking, health care is about the pursuit of health and healing. Seedhouse (1986) points out that any discussion of health care begs the questions, 'What is health?' and 'How can it be achieved?' Addressing these two questions is not simple because health is a value-laden concept and has a tendency to draw controversy into any in-depth discussion. Indeed definitions of health vary so widely that one could be talking about a range of vastly different aspects, concepts and approaches when health or health care is the topic. However two broad philosophical approaches to health and health care can be noted which are related to fundamental beliefs of reality, the holistic and analytic or biomedical approaches.

What is health?

Health is a term that is used so frequently in society and day-to-day conversation that its meaning is commonly taken for granted. Yet, health means different things to different people and in different contexts. There are a number of theories on health (Dubos, 1979; Seedhouse, 1986; Nordenfelt, 1995) which contribute to the great diversity of the ideas of what health is. Importantly an individual's beliefs and practices of health relate directly to their beliefs in other areas of their life (Kermode, 2004).

The difficulty in defining health is observed in Blaxter's (1990) findings from interviews of nine hundred lay individuals at the University of Cambridge Clinical School. Individuals were asked what they thought 'health' was. Fifteen per cent of the participants were unable

to answer the question and a larger percentage (particularly male) considered health to be so ordinary and normal that it was difficult to describe.

Of the remaining respondents, the perception of what health was varied with both gender and stage of life. Generally, males under forty saw health as being strong and fit, while females under forty, saw health as primarily related to fitness and appearance. They also included the ideas of energy, vitality and ability to cope. In the middle age group, the concept of health became more complex, relating to overall mental and physical wellbeing. The older group saw health as the ability to do and function, along with being content or happy. This study demonstrates the difficulty for people to adequately and confidently describe health, displays the diversity that occurs within those that can, and underlines the fact that generally people see health as relating to quality of life and the ability to do what they need to do, that is their lived experience.

Along with the different ideas of what health is there are multiple approaches to health care. Health care may be to treat or prevent a condition, or to enhance health. According to Seedhouse (1986) health care providers that focus on treating disease and illness set their sights too low. There are models of health care that go beyond the 'disease free' model enabling people to stay healthy, via education and lifestyle choices (Ryan & Travis, 1991; Sarafino, 1994). In these models experts provide education designed to increase an individual's ability to choose healthy lifestyle practices and increase their level of wellness.

As part of this healthy lifestyles approach, over the past 30 years, psychological research has developed increasing awareness of the importance of understanding the relationship between physiological and psychosocial factors that can effect the outburst of disease and ways of coping with disease and preventing them (Jacoby, 2003). The role of the social environment in health is increasingly accepted as a recognised area of health care. Health psychology has provided a meeting ground for psychology and medicine incorporating a shift from the biomedical model to the biopsychosocial model. This meeting ground has also resulted in the development of new fields such as psychoncology and psychoneuroimmunology (Jacoby, 2003) as well as a field commonly known as body mind medicine.

The increasing interest in the psychological factors in health also shows increasing interest in the role of the human spirit in health. Hope, optimism and happiness (Seligman, 1991; Jacoby, 2003) play an increasingly important role with regards to health in psychology. Further some medical practitioners are beginning to consider the role of love and connection in maintaining good health (Ornish, 1998).

Levels of responsibility for health care

Seedhouse (1986) mentions three primary levels of health care: social, medical science, and humanistic. Similarly Schubert-Lehnardt (1995) describes three levels of responsibility for health care: the individual and their family; the professional worker and the institutions that support them; and the community, town, or state. On the other hand Seale (2001) describes three broad sectors of health care: lay, professional and alternative. Importantly while it is possible to indicate these levels distinctly in practice there is much blurring and crossing of boundaries between the levels particularly in regards to individual responsibility and expert care. Who is responsible for health care can be considered in terms of the community, the professional and the individual, with overlapping boundaries between them.

Generally the state as the social organiser has responsibility to all members of the society and, as such, is responsible for the community level of health care. It can be seen in public sanitation, health promotion programs, provision of public health care, setting of standards for and regulation of health care providers. This is similar to, but not the same as Seedhouse's sociological approach which relates to society as a group and the health of its members. However, the primary concern of the sociological approach is the causes of illness and diseases and how we can be healthy as a society, it leans more to the academic than the practical. The state level of health care is in part the practical aspect of the society's health which is influenced by the academic.

The professional or expert approach to health care refers to the practitioners of health care, the person or organisation that individuals go to for expert assistance, personal advice and care. Practitioners of health care are specially trained in their field to enable them to carry out their role as health care providers. Seedhouse's medical science approach is that of biomedicine framework. This approach is currently the dominant expert health care provider in Western societies. Seale's alternative health care is any other form of health

care (that is, health care not recognised within the system) including alternative expert providers.

The individual level of health care relates to what each person can or does as an individual to obtain and maintain his or her own personal health. Unwell individuals tend to practice self-help first and then visit a health care professional later, if necessary (Vincent & Furnham, 1997). Traditionally family and friends are the first source of health care with females being the predominate providers (Pelling, 1997). Related knowledge is incidental to life learning, rather than the special training of an expert, it is about people looking after themselves and their family. One important point is that constantly, at least in Western societies, it appears that the family was and still is the first port of call for advice about illness (Pelling, 1997).

The humanistic approach to health views health as a personal goal for which individuals should be free to strive for by their own efforts, where health is more than a 'disease free' state. Seedhouse's humanistic approach could be seen as representative of an alternative expert health care provider that supports the process of health care by providing information and assistance for individual and personal self health care. However it relates to what individuals can do for themselves and the responsibility to do what one can. This overlap between professional and individual health care is an example of how the boundaries blur between the levels.

Dougherty (1995) refers to a two models approach for health care, one model is the freedom model and the other is the facticity model. The freedom model refers to individual control of health where an adult has the ability to make choices. It focuses on human dignity in that individuals have a right of choice and are responsible for their choice. Indeed they are morally responsible to make appropriate choices. The facticity model is where health is considered to not be within an individual's control. It maintains that behaviour is determined by social, economic and cultural circumstances rather than being a freely chosen activity. In this model responsibility is placed on the political, social and cultural systems. Both approaches have their benefits and disadvantages particularly when strictly followed. Consequently Dougherty (1995) refers to an appropriate framework for health promotion that promotes individual effort while maintaining sympathy for those in

need. That is an integration of the two models and a balance of responsibility between society, experts and the individual.

II Two Philosophical Approaches to Health and Health Care

Nordenfelt (1995) puts forward two general approaches to health, the holistic approach and the analytic approach. They are philosophically different based on different views of reality. The first 'holistic' view holds that individuals are part of a larger whole existing in unity affected by all, yet the individual grows on his or her own unique path as directed by his or her soul. Alternatively the analytic approach views the individual as a physical organism that can be understood and controlled by reducing it to its smallest part and maintaining it within the normal range.

The holistic approach to health

According to Nordenfelt (1995) the holistic approach to health looks at how the person feels, what they are able to do and how they function as a member of society. There are a number of theories of health within the holistic approach. These include: health as role performance, the physical and mental fitness to perform socialised daily tasks (Smith, 1983; Seedhouse, 1986); health as the ability to adapt, a metaphysical strength (Smith, 1983; Seedhouse, 1986); Smith's (1983) eudaimonistic model, with health as self-actualisation and self-fulfilment; health related to energy balances (yin/yang, four bodies adjusting); and poor health related to disturbance of the soul (Glockler & Goebel, 1990). Definitions of holistic health are expansive and variable however they relate to the person as a whole and usually relate to their growth or their community. This approach relates to ordinary people and their experience of life.

Examples of approaches to holistic health include the view of Glockler and Goebel (1990) that 'health in a human being is the ability to be open to and be interested in the phenomena of the world around them; furthermore, to be in a position to share the world's problems and to do all in one's human power to set them right.' Here health relates to learning, healing, suffering through the illness and liberating the 'I' from imbalances. They state human health requires that the 'I' be able to make use of its capacities freely and in a manner that is appropriate to any given situation. 'It is on our very capacity to love that

health is founded' (Glockler & Goebel, 1990). Similarly Ornish (1998) states 'love and intimacy are at the root of what makes us sick, and what brings happiness'.

Alternatively Seedhouse (1986) states that a person's health is equivalent to the state of a set of conditions that fulfil or enable a person to work and to fulfil his or her realistic chosen and biological potential. Importantly, a person's state of health cannot be separated from their quality of life (Seedhouse, 1986). Sacks (in Seedhouse, 1986) sees health as personal fulfilment, happiness, a sense of reality and feelings of being fully alive, whatever is personally fulfilling. According to Illich (1976) health is a task that each individual is responsible for, he states that 'success in this personal task is in large part the result of the self-awareness, self-discipline and inner resources by which each person regulates his own daily rhythm and action.'

In holistic health, health is believed to be a matter of natural balance. Consequently health is a dynamic, vital, process that involves the maintenance of internal balance, repair and restoration of normal function, the expansion of consciousness, development of skills and resources of self regulation and the achievement of wholeness (Dacher, 1996). The holistic approach to health argues that health is multidimensional and thus one may be healthy in some dimensions and not others (Seedhouse, 1986). Indeed one could have a 'disease' and still be healthy. Dimensions of health include the physical, emotional, cognitive and spiritual, where the soul is at least as important as the physical body. Further health is influenced by a number of external factors, both physical and social. This view of health is reflected in the definition that states 'health is a positive state of physical, mental and social wellbeing, where the presence of disease and illness moves to one end of a continuum and increasing levels of wellness towards the other' (Sarafino, 1994).

Overall according to the holistic health approach, health relates to one's being and soul. It is the result of healthy life practices, meaningfulness, personal responsibility and a 'capacity to love' (to care). The practice of holistic health care aims to empower the individual to enhance their health, quality of life and become more of who they are. It recognises that health is more than a physical reality, emphasising individuality within the community, caring and uniqueness in healthy functioning.

The analytic or biomedical approach to health

The biomedical approach to health is based in analytic science where the approach to health is known for its reductionist view (Featherstone & Forsyth, 1997) and is founded on the belief that health is naturally present in the absence of disease or the presence of 'biological normality'. According to this approach health relates to parts of the human organism and their function and structure being maintained within the normal biological range. For biomedicine health is physical in nature.

In this approach the lack of health has specific aetiology, the descriptive classification of diseases and therapies to combat them (Nordenfelt, 1995). Thus diseases are defined by sets of symptoms identified by medical science (Seedhouse, 1986) the causes of which include: failure of homeostasis; heredity factors; or the intrusion of foreign substance such as microbes or chemicals (Smith, 1983). Being physical in nature health is dealt with at this level.

Health care is considered a form of engineering based on detailed understanding of how the body works. This knowledge is used on bodies not people in the form of impersonal interventions (Nordenfelt, 1995). Health is maintained by technical expertise and is seen as a commodity that can be purchased from a doctor who will fix the problem with little input from the client (Seedhouse, 1986). Just in case interventions are sanctioned as appropriate procedure (Featherstone & Forsyth, 1997). Illness on the other hand relates to the experience or feeling people have when unwell (Seedhouse, 1986).

Barry and Yuill (2002) list five characteristics of biomedicine: mind body dualism; mechanical metaphor; technological imperative; reductionist and; doctrine of specific aetiology. In biomedicine health care is provided in the form of a physical intervention intended to normalise and fix a condition provided by authoritative professionals in health care.

Distinguishing between the holistic and analytic approaches

The two views of health and health care relate to two basic assumptions of reality. The first reality purports we are spiritual beings, that we have a soul or human spirit, thus there is more than the physical. The analytic approach operates from a base of physical reality.

These basic philosophical premises are the foundation of practice and have important implications for the practice of health care and how the patient is treated. For in the first reality the spirit of the individual is equally as important as the physical body, while in the second it is simply not considered. As part of the process of integration in health care it is important to question how well these two philosophical views match and just how they can be integrated.

The physical view of reality relates to the biomedical model. In this model practice is based on the treatment of a condition with the principles of analytic reductionism, determinable casual relationships and a hierarchical or authoritative approach, where the expert determines the appropriate treatment. Alternatively the holistic model is a cooperative approach, aiming to stimulate an individual's own healing or growth process, allowing each individual to choose the health care practice most suited to them, with the soul or spirit of the individual directing the outcome related to their personal lived experience. In this view the expert is a partner providing information and support to empower individuals in their health care. Predictable outcomes are not a basic premise. The centrality of 'vitalism' in holistic practice is noted, it refers to the 'healing power of nature,' an individual's own 'innate self-healing capacity' which can not be seen, harnessed nor measured with any quantitative certainty (Grant, 2003a; Villanueva-Russell, 2005). Table I outlines the philosophical principles of each approach.

Blaxter (1990) points out that the holistic approach to health is a looser model than the analytic model. According to Featherstone and Forsyth (1997) ideally the holistic approach to health care embraces all paradigms and manages to integrate them in the best interest of the clients. With an inclusive approach to its practice the holistic approach supports the appropriate use of biomedicine in health care. However it is noted that neither the inclusion of multiple dimensions nor the use of the label 'holistic' means holistic principles are being practiced. Indeed many CAM therapies today may practice in the mode of categorising and predictive outcomes making them analytic or reductionist in nature. Care is required to avoid the assumption that all CAM groups are holistic and translating that to the view that CAM and biomedicine are two distinct paradigms when it is holism and analytic reductionism that provides the different philosophical bases to health care practice. However as noted by Blaxter (1990) and Featherstone and Forsyth (1997) and indicated in

Table I, holistic practice is a practice that embraces all in the best interest of the individual including the reductionist principles of biomedicine.

Table I
Principles of reductionist and holistic health care practice: A comparison of the distinguishing characteristics of two broad approaches to health care.

Reductionist	Holistic
Categorising process	Individualising process
Objectification	Personification
Either/or thinking	Both/and thinking
Hierarchical approach	Co-operative approach
Opposition	Complementarity
Activism	Presentism
Future-time orientation	Present-time orientation
Focus on state	Focus on movement
‘seeing is believing’	‘believing is seeing’

Sourced From Featherstone and Forsyth 1997

Confusion between the two paradigms particularly shows up in regards to the ‘body mind’ approach that may, philosophically, refer to a holistic or an analytic approach to health care. ‘Body mind’ medicine based on the reduction of the whole into parts is reductionist regardless of its label. Further Dacher (1996) points out that no matter how well intentioned a practitioner maybe a practice strategy that involves one person (usually considered the expert) doing something to someone else must fall under the treatment (analytic) system as we know it. Whilst holistic principles embrace the appropriate use of analytic health care the basic premise of analytic reductionist principles does not support the use of holistic principles within its framework. Pearl (2005) speaks in terms of a protective, catalytic healing versus determining, controlling health care to distinguish between the two approaches and asserts the need to distinguish clearly in order to understand ones role as a healer.

The confusion between the two philosophical approaches could be a reflection of what Evans (1996) describes as difficulty distinguishing between two realities perhaps even being unaware that there are two. According to Evans (1996) this difficulty results from

individuals growing up in a hierarchical (power over) model of reality and emerging into a personal power (empowerment) model. Evans (1996) speaks of two models of power, power over and personal power. The power over model is an aspect of causal reality, the basis for the biomedical approach to health and a reality that emphasises control and dominance. The personal power model shows up as mutuality, co-creation and unpredictability, as seen in holistic approaches. Evans points out that western civilisation was founded on the hierarchical model of reality and this model is so prevalent in western societies that it may appear as natural, she asserts it is not.

Aligning with the empowerment model Mowbray (1995) and Hall (1993) promote the importance of the individual making their own choices as to what is best for them, so they are no longer dependent on experts¹. An intention of this approach is to reduce individuals' tendency to choose from a space of victim-hood which Hall argues is a natural consequence of causal reality. This humanistic approach clearly lacks the normalising and authoritative hierarchical aspect of reductionism. They are promoting a holistic approach to healing at a psychological level.

III Historical Development of Biomedical Health Care

Generally speaking ideas, understandings and practices are constantly changing with the present building on the past. This is also true for health care. Peacock and Nolan (2000) note that it is important to understand that today's health care has grown out of past health care and that the definition of care has changed over time. More specifically Porter (1996) points out that the medical profession is in continuous transformation demolishing old dogmas and building on the past. Medicalisation of health care is a fairly recent change which began with the development of science and biomedicine.

In the pre modern period, prior to the medicalisation of health care, health was about wholeness and soundness of body and mind (Seedhouse, 1986). The qualities of vigour, suppleness and fluidity were seen to be lost in illness, and medicine's task was to restore these qualities. Healing was considered an element of health and related to an individual's ability to recover from disease. In the 17th century the soul was seen as a constantly

¹ This is consistent with Illich's arguments whose work is mentioned on page 26/7.

intervening presiding power, the very quintessence of the organism, the ever-active agent of the consciousness and the physiological regulator (Porter, 1996). Disease was the disturbance of vital functions by malaise of the soul. Thus neither anatomy nor chemistry had much explanatory power and healing required understanding the soul (Porter, 1996). Health care was based on 'caring' in the form of ethical relationships as an expression of humanity with the intention of restoring both spiritual and physical wellbeing (Peacock & Nolan, 2000). This was in opposition to the Cartesian view that the body was like a machine.

René Descartes set the stage for the development of scientific biomedicine in the 17th century (Sarafino, 1994). In the 18th century the Cartesian view was put forward providing a mechanistic basis for the separation between the body and soul. The development of this way of looking at the body was supported by cultural, social and economic changes that provided the opportunity to question previously held religious and supernatural beliefs of why disease occurred (Barry & Yuill, 2002). The performance of dissections and autopsies provided information on how the body functioned and the physical qualities of disease. From this time on analytic biomedicine developed and became widely accepted.

The further evolution of scientific explanations for disease, such as the development of germ theory, was supported by the use of scientific experimentation and the development of equipment such as microscopes. Science enabled the rapid development of diagnostic and intervention tools for disease (Porter, 1996) and the ever expansion of a medical knowledge base. The belief that science would one day provide the 'magic bullet' to 'cure all' inspired not only faith in the expert, but also the handing over of power to them. As a consequence health care moved away from lay practitioners. This resulted in health being separated from the experience of illness and health care being taken out of the hands of the individual (Seedhouse, 1986). No longer did the personal experience or the soul matter in health care.

Medical practice is based on continuously expanding theoretical knowledge of the physical body. Thus it is increasingly specialised requiring educated practitioners and reinforcing the need for experts. Along with the development of scientific knowledge technology has increasingly played a role in health care. Over time it replaced care based on the Christian

paradigm to the point that the traditional caring role is increasingly being replaced with scientific technologies (Peacock & Nolan, 2000).

Criticisms of biomedicine

Health care is a practice intended to improve health. Unfortunately this is not always the outcome and biomedicine has been criticised for this and a number of other reasons. Illich (1976) argues that biomedicine is counter-productive and has a negative effect on health. He contends that the disabling impact of professional authoritative medicine has reached the proportions of an epidemic and it is up to the public to reclaim influence over medical perception and decision-making. Seedhouse (1986) lists the problems of biomedical health care as: its predominate concern with the structure and function of the body; its disregard of the unquantifiable aspects of people; the belief that full objectivity is possible and appropriate; and the idea that health can be quantified. The result of this view is that the patient is reduced to an object whose body is to be repaired. The patient becomes a 'case' no longer a subject being helped to heal. Consequently biomedical health care is depersonalised and disempowers individuals (Illich, 1976).

Biomedicine is criticised because of its emphases on objective quantification of the health of the physical body and neglect of the unquantifiable aspects of the individual. This results in the loss of humane caring which is argued to be the 'heart of healing'. With the increased quantification of care traditional care has been replaced with technical care. Peacock and Nolan (2000) suggest that the technological strategies used to reduce suffering have generated new forms of pain and disease and that 'when care becomes the mere servant of technology, health services are fast becoming meaningless.' They argue for the return to the use of the human aspect of caring, with caring an essential element of curing and suggesting that health services based in care are likely to be more cost effective.

The cost of health care has increased directly related to technology and practitioner needs, rather than being maintained as an affordable, efficient service focused on individual needs. Illich (1976) argues for effective rather than technical treatments asserting that the most effective treatments are low cost. Expanding this view Navarro (1976) argues that medicalisation and the increasing intervention by medical practitioners is due to the consequences of the capitalist society with the elite using it as a means of control and profit. McKnight (1977) further argues that medicine has become needs rather than service,

orientated. That is the need to earn an income takes precedence over service to the client. This approach arises from the idea that in society ‘the most fundamental problem that faces every individual is the problem of ensuring his or her own economic reproduction, for people must eat in order to live’ (Olga 1996). Illich (1976) argues that the provision of services has become self-serving and costly.

It is further argued that biomedicine plays a role in the creation of new diseases (side effects of drugs, iatrogenesis, cultural and social iatrogenesis) and weakens tolerance to suffering (illich, 1976). This in effect means that everyone has something wrong with them and reinforces an attitude of always looking for a miracle cure and increases dependence on medical practice, this handing over of power is heavily criticised. Porter (1996b) states that consumers and doctors are locked into a ‘can-do, must-do’ mentality that is looking for perfect health. The over all effect is to create over-dependence on technical fixes (Illich, 1976).

Illich (1976) further argued that consumer protection turns quickly into a crusade to transform independent people into clients building on the ‘need to earn’ concept. Aron² (2003) suggests that this change in focus maybe due to a change in the type of person dominating the profession. She suggests that non-sensitive people have driven sensitive people out of the profession and that non-sensitive people are more concerned with immediate results including profit, than quality of service and long-term consequence.

Biomedicine is criticised because of its ‘authoritative expert’ approach which disempowers and establishes a systematic process of dependency of individuals via the creation of diseases, labelling, use of medical terminology and the medicalisation of many aspects of life. Illich (1976) states that the degree to which medicalisation has infiltrated daily life is analogous to the power of religions where doctors are the new priesthood. Illich’s criticism of the over medicalisation of life relates to a loss of personal control which he argues is a significant factor contributing to poor health.

² Aron refers to sensitive and non-sensitive people related to the degree of responsiveness to stimulation and the effects that it has on their beingness.

IV Growth of CAM in Australian Health Care

In Western societies the use of natural therapies is increasing among the general population and health care workers alike (Knape, 1998; Zollman & Vickers 1999; Hall & Giles- Corti, 2000; Perry & Dowrick, 2000; Thomas, et al 2001; Ching & Seddon 2003). Lewith (2000) states that in a free market such as Australia the economic and social pressure will encourage the continued development of CAM. The international increase in the use of CAM is such that the World Health Organization (WHO) launched the first global strategy on traditional and alternative medicine in 2002 (WHO, 2002). The strategy aims to assist countries to: develop national policies on the evaluation and regulation of traditional medicine (TM)/CAM practices; create a stronger evidence base on the safety, efficacy and quality of TM and CAM products and practices; ensure availability and affordability of TM and CAM, including essential herbal medicines; and promote therapeutically sound use of TM and CAM by providers and consumers alike.

There are numerous studies that indicate the use of CAM is prevalent and continues to expand in Australia. Hall and Giles-Corti (2000) report that between 1970 and 1986 there was a twelve-fold increase in complementary therapists. More recent figures reported by MacLennan et al. (1996) indicate that 48.5% of 3004 South Australians surveyed had used at least one non-medically prescribed alternative medicine in the previous year and that 20.3% had visited an alternative practitioner in the same time. These figures increased slightly to 52.1% and 23.3% respectively over the next seven years (MacLennan et al., 2002). In a recent survey of 832 nurses in NSW 74% had used a complementary therapy in the last year, 38% had used one on a patient and 67% said that they would refer patients to a complementary practitioner (Wilkinson & Simpson, 2002). Overall these figures indicated that nurse practitioners are more likely than the general public to use CAM. Further Wilkinson (2001) found that 78% of 376 students in undergraduate bachelor of nursing, pharmacy and biomedical sciences reported having used complementary therapies in the previous year and 56% reported attending a complementary practitioner in that time.

Indeed general practitioners (GPs) and nurses are displaying interest in CAM, including training in them. A survey of 282 Perth GPs found that almost half had undertaken studies in complementary therapies while 60% want further training (Hall & Giles-Corti, 2000). Meanwhile Pirotta et al. (2000) reported that of the 488 responding Victorian GPs 93% felt

some education on CAM ought to be included in core medical undergraduate curricula. Kellehear (2003) reports that 94% of Monash medical graduates planned to practice some form of natural therapy alongside conventional medicine. Clearly not only are complementary therapies increasingly popular but health care workers, including medical practitioners, are accepting them.

Myers (2002) suggests that it is irresponsible to ignore the increased use of natural therapies in Australia and Pearson (2004) recommends that orthodox practitioners learn more of CAM so they may understand their patients better. Indeed some Australian medical schools are instigating training in CAM (Brooks, 2004; Owen & Lewith, 2004) and the La Trobe Report (2006) recommends that general practitioners be ‘encouraged to undertake continuing education to increase their understanding of CAM, as a basis for improving interdisciplinary communication as well as appropriate advice for their patients.’

Complementary medicine has appeared as a subject of study and training in the Australian university system (Wilkinson, 1997). A growing number of Australian universities are offering education in complementary medicine (Democrats, 2004) including as: part of nurse training, part of medical training and modalities in their own right within a bachelor of science. At least twelve universities are offering courses in CAM, with some including postgraduate studies (UNE, 2006). Other sources report that there are at least 16 degree courses in ‘unorthodox’ practices, along with courses at colleges and independent training providers (Brooks, 2004). Some universities offer an upgrading course for those with an approved and government accredited qualification at the Diploma or Advance Diploma level in a complementary medicine modality (CSU, 2006). The La Trobe Report (2006) recommends that these CAM courses be reviewed on the basis of the WHO guidelines for education and quality assurance in traditional medicine.

Collaboration between practitioner associations or private providers and universities is also occurring. Pearson (2004) reports that the Australian Traditional Medicine Society (ATMS), reported to be the largest professional association representing CAM in Australia, has accredited courses that have partnership arrangements with a university allowing students to graduate with a bachelor of health science degree. While the University of New England provides a Bachelor of Health Science in collaboration with the Australasian College of Natural Therapies, a leading private provider of Naturopathy education.

Reasons for the growth in natural therapies use

Dissatisfaction with orthodox medicine is said to be a factor in the increasing popularity of CAM. Wiesner (1995) reports Australian research has found that the major reason for choosing alternative therapies is dissatisfaction with conventional medicine. Sharma (1990) lists criticisms against orthodox medicine resulting in turning to CAM as: the claim that conventional medicine fails to get at the root cause of chronic illness; the fear of drugs that might become habit forming or the dislike of side-effects of particular drugs; fear or dislike of forms of treatments that seem too radical or invasive; the perceived inability of conventional medicine to cope with the social and experiential aspects of illness; and dissatisfaction with the kinds of relationship between the doctor and the patient.

However there appears to be other aspects influencing the process. Shenfield et al. (1997) reports a Sydney based survey found that reasons for the use of alternative therapies included 'to feel better', 'to clean up the system' and other general reasons. Similarly, Wilkinson (2001) reported that surveyed students felt complementary therapies improved quality of life and gave hope when conventional therapies failed. It seems that people are looking for more than disease care which the current health care system focuses on.

Donohue (2003) states: 'It is worth remembering that Australia has no health care system. Medicare is a disease care system, and the Pharmaceutical Benefits Scheme (PBS) is a drug subsidy system for disease treatment'. Brighthope (2004) asserts that the focus on disease care rather than prevention and optimisation of health is costly both financially and in terms of human suffering. Prevention and health management are largely left to individuals and paid for out of their own pockets. The indications are that Australians are looking for more in their health care and are willing to pay for it.

Further Lewith (2000) suggests that individuals use CAM as part of their process of empowerment and that with their increasing knowledge they are seeking a more egalitarian process in consultation. Furthermore Barry and Yuill (2002) found that better informed patients aware of their right to adequate care, along with alternative practitioners asking questions of the effectiveness and the potential damaging effects of orthodox medicine were additional reasons for choosing CAM. This challenges the concept that 'doctor knows best' and that they have 'clinical autonomy' allowing them the freedom to make choices for their client based on their expert knowledge (Barry & Yuill, 2002).

O'Callaghan and Jordan (2003) indicate the increased use of CAM is related to a post-modern anti-authoritative (especially science) view and the emergence of a new set of health values in society. A growing awareness and interest in the 'green movement' or 'power of nature' and 'personal responsibility' via individuality and empowerment, along with the view that 'knowledge is power' has influenced individual's views on health care. This change is observed by the growth in CAM and can be interpreted as indicating a paradigm shift. This shift described as a move away from the modern science authoritative view, to a post-modern, anti-science, quality of life and personal choices (responsibility) in life approach. Siahpush (1998) asserts that a post-modern view is an effective predictor of the use of alternative therapies. Coulter and Willis (2004) suggest that increased migration and the politicisation of health care may also play a role in the increase of CAM use.

While some attribute the growth in CAM use to individuals not being satisfied with the current system, a similar yet more positive view is that individuals are looking for health care, rather than just disease care, as part of their process of empowerment and personal responsibility. With increased knowledge and awareness of their rights, in particular their right of choice and desire for improved quality of life, able individuals are choosing their approach to health care. The indications that a preference to use CAM is more economically sustainable may be part of the driving force or simply fuel for the fire. Either way with Australian's spending in excess of \$2 billion a year on CAM (Democrats, 2004; Mac Lennan, 2002) the Australian public appears to see value in CAM. People are voting with their dollars for a health system promoting holistic principles rather than a purely analytic disease care system.

Indeed the dissatisfaction and concerns of conventional medicine combined with the desire for consideration of the social and experiential aspects of illness and a more egalitarian relationship between the doctor and patient is driving the move toward holistic health care services and CAM. The medical profession has dominated health care for some time riding high on the idea of the magic bullet, the power of science to cure all. Unfortunately this promise has fallen short and the medical profession is losing its power over individuals (Barry & Yuill, 2002).

V Biomedicine's Criticisms and Conditional Acceptance of CAM

According to Kellehear (2003) the medical profession has a long history of antipathy and resistance to complementary health care. In the 1980s the Royal Australian College of General Practitioners (RACGP) produced a defensive and critical examination of complementary medicine. Indeed, Cohen (2004) suggests that some doctors may still recall a time when they would have been faced with disciplinary action if they engaged in such “unorthodox practices.”

Arguments from the medical profession against CAM continue to this day. These arguments are primarily about safety and efficacy of treatment and include: concern about an assumption that CAM is safe; concern about delayed access to proven effective treatment; and concern that individuals do not report the use of CAM therapies to their GP, despite using prescribed medication at the same time (Shenfield et al, 1997). Pirota et al. (2000) add the inability to generalise effectiveness of a CAM therapy as a reason for concern. Whilst MacLennan (1999) lists the four harms of harmless therapies as possible side effects, the high cost of ineffective treatment, delayed treatment with effective evidence-based treatments and disappointment following the failure of such therapies.

In opposition to medical arguments against CAM it is counter-argued that using medical care as the first choice often delays important natural care (Pearl, 2001) and that CAM with less side effects ought to be offered as first options (Featherstone & Forsyth, 1997). Importantly Parker (2004) points out that generic risks of CAM such as withdrawal from appropriate medical therapy and failure to be diagnosed or referred appropriately are considered in the context that orthodox therapy is accepted as appropriate. Lewith (2000) asks ‘Why should we impose our medical model on patients?’ while acknowledging the difficulty for those educated in the conventional medical system to allow patients the freedom to travel such a path in a truly egalitarian manner.

A more significant point is that medical practice itself does not provide a high level of proven or safe practice. Goodman (2003) notes that only 10-25% of medical decisions are based on good quality evidence, which leaves up to 90 % not based on high quality evidence. The result is that biomedicine is just as vulnerable to issues of providing proven effective treatments as CAM and concerns of delayed access to proven treatments provided

in medical care are not supported by current evidence. While evidence shows that adverse events in hospitals are relatively common place, being reported to be between 3.5% and 16.6%, with an average of 1 in 10 hospitalised patients suffering some form of preventable harm (WHO, 2004) and 3 in 1000 dying as a consequence (Lazarou et al., 2007). While any assumption that CAM is safe is questionable the evidence clearly demonstrates the risks of biomedicine. At present there is a lack of evidence that biomedicine is any safer or effective than CAM.

Komesaroff (1998) calls for a 'much-needed dialogue between practitioners of orthodox and complementary medicine.' The process of the two fields working together is under way says Kellehear (2003). He states that when the British Medical Association (BMA) began to advocate collaboration with CAM in 1993 an important change was instigated. Indeed he suggests that the alleged contrast and perceived rivalry between mainstream and complementary medicine is not reflected in reality. Complementary practitioners widely recognise the value of orthodox medicine, especially for accidents, emergencies, infection and near death. Some refer and defer to medical practitioners and rely on orthodox practitioners for diagnosis and screening procedures. This view is reinforced by the idea that it is no longer believed that: there is a single cause of disease; that there is only one way to heal; that the power to heal is exclusively in external agents; and that the biomedical health profession has all the answers (Dacher, 1996).

Morton and Morton (2003) suggest that health consumers who use alternative medicine may know something about getting well medical practitioners do not. They also suggest that the growing interest in CAM by medical practitioners will result in a scenario where the greatest number of practitioners of CAM will actually be medical doctors, stating that many physicians are recognising that they can be even better doctors by integrating unconventional and alternative medical treatments into their conventional practices. Indeed, in Australia general practitioners using CAM in their practice are no longer on the fringe with an increasing numbers of Australian general practitioners showing interest in CAM (Cohen, 2004).

However there still is uncertainty that the use of CAM is mainstream or that it is accepted as part of the general practice and recognised by the power structures (Myers 2002). Importantly public awareness for this change is growing. A women's magazine article

titled 'A natural progression' (Sparke, 2004) was on medically trained doctors who were also trained in complementary therapies. It referred to the Australasian Integrative Medicine Association (AIMA) the peak body for medical practitioners who integrate CAM into their practice (Cohen, 2004). Continued growth of acceptance is indicated as the La Trobe Report (2006) suggests that the medical referral to some CAM modalities (acupuncture and massage) may be considered mainstream. The La Trobe Report is a major step toward increasing CAM as part of mainstream health care with recommendations to increase communication between practitioners (CAM and GP) noting the importance of doing so.

Ultimately the growth of CAM has resulted in the need for the medical profession to go beyond resistance. The profession has been forced to act and is doing so by moving into acceptance and integration of CAM into its system. Today there are multidisciplinary clinics that offer CAM and mainstream services (Cohen, 2004). In support of this the RACGP (Online, 2000b) comments that just because we do not know how something works it doesn't mean that it doesn't work, pointing out that acupuncture and meditation are gaining acceptance in orthodox medicine. There is strong evidence that homeopathy, acupuncture and meditation do work and this is challenging medical practitioners to think about the body, energy and mind in more flexible ways.

In addressing the integration process the health care system primarily argues for the process to be under their rules demanding evidence-based practice in particular, evaluation and regulation for safety and efficacy. The call for evidence is claimed to be in the public's best interests. Yet it has been indicated that the public are looking for more than the traditional medical disease care and are looking for meaning, context and a more egalitarian service that empowers them to feel better and take more responsibility for their health. It is evident that the medical profession now faces the challenge by demanding evidence of claims, yet it is also clear that evidence based practice is not the only issue that needs considering in the process. Indeed there is acknowledgement of the 'cultural and political changes demanded of medicine in the 21st century' (Lewith & Bensoussan, 2004).

Cohen (2004) lists other obstacles to the integration process as issues related to the credentials and regulation of CAM practitioners; the difference in nomenclature between

disciplines; equity of access in different health care settings; appropriate funding models and medicological issues. However he notes that these obstacles can be overcome and that the value of integrative health care provides incentive to do so. Other expressed concerns include legal and ethical considerations and the nature of the professional relationship when 'share care' is operating (Lewith & Bensoussan, 2004). The credential and regulation issues have also been worded 'essential that we establish the professional competence and safety of CAM practitioners' (Lewith & Bensoussan, 2004) highlighting the expressed concern about the quality of CAM practice and practitioners.

Lewith and Bensoussan (2004) describe integration as 'the selective incorporation of elements of CAM and conventional medicine.' They note 'true integration will only be possible if CAM commits to appropriate scientific scrutiny and if treatment guidelines are developed that clearly dictate when one option should be selected over (or alongside) another'. With the expressed view that medical professionals 'can no longer just be the "possessor of knowledge" but must also provide interpretation and wise counsel.' Importantly Lewith and Bensoussan (2004) note that 'pluralism' with mutual respect between contrasting systems, and 'harmonisation' a diplomatic approach of working together, are alternative approaches for the relationship between CAM and biomedicine.

Owen and Lewith (2004) note that it is important to remember that CAM do have a range of diverse philosophical and practice systems which require a different understanding of health. The importance of respecting the different views of health and health care are clearly indicated by Seedhouse (1986) when he states that it is important that when working in a field that impacts on others, such as health care, that one recognises that not everyone has the same values and priorities and that it is really important to grasp and work with the client's values and priorities rather than impose one's own. The importance and value of greater diversity and choice in the health care system is coming to the fore.

Despite the increased use of CAM there is still a view that alternative approaches are soft. This view is reinforced and strengthened because CAM's knowledge base tends to be unscientific, relying on folk knowledge or personal experience. The depth of belief in the value of the biomedical system and the view that CAM approaches are soft means individuals still turn to biomedicine for serious conditions (Schnaubelt, 1999).

Summary

Health care is a significant service and industry in our society. Of the two primary approaches holistic and analytic or biomedical, biomedical is the current dominant approach to health care. CAM is increasingly challenging biomedical dominance in health care. This is primarily due to demands by the public who are increasingly taking an interest in preventative, natural health care and are looking for more caring, humane choices in their health care. There is social pressure for greater quality of life, wellbeing, personal choice and 'holistic' approach to health care. This has resulted in steps being taken to integrate CAM into the Australian health care system.

This time of transition, where the dominant paradigm in health care has been forced to make adjustments due to the continued and persistent growth of a sub paradigm, can be referred to as a social crisis. There are at least three core issues that can be noted in this crisis the: escalating costs (technological and private); challenge to authoritative power of the medical profession; and the demand for natural and more humane service. This study's interest is primarily on the last two issues, the increased empowerment of individuals in their health care and the provision of more natural products and humane services. In the next chapter how the Australian Government is responding to the increased demand for CAM will be reviewed.

Chapter 2

The Australian Government And Complementary and Alternative Medicine

*Thousands of health conscious and informed people are protesting
against the disappearance of health freedom.
People are demanding their right to stay healthy
Eve Hillary, 2003*

The growth of and demand for CAM has resulted in the acceptance of CAM as part of the future health care system in Australia. Yet just what role CAM will play and how CAM will be integrated into the established system is still a matter of concern for many. The Australian Government has not missed the significance of the increased demands for CAM, nor the expressed concerns by the medical profession outlined in the previous chapter.

As the body responsible for the health and safety of the public and the regulation of practitioners and therapeutic products, the Australian Government plays an important role in the growth and development of CAM in Australia. Thus what action the Government takes is vitally important to the development of CAM and its integration into the health care system and consequently the professionalisation of aromatherapy in Australia. This chapter will review current developments in this political area of importance including calls for government action such as regulation and research for evidence based practice.

I Regulation

The primary role and responsibility of the Australian Government in regards to health care and CAM development is for the safety and wellbeing of members of the society as a whole, as such they regulated both therapeutic products and practitioner. Significantly the government has taken important steps to clarify CAM's standing via the Therapeutic Goods Act 1989 (TGA). However regulation of CAM practitioners which has been noted as an issue (Cohen, 2004) has a number of considerations.

Regulation of CAM products: TGA

The government has taken important steps to clarify CAM standing via the TGA. In Australia all therapeutic goods are regulated by the Australian Government under the TGA, which came into effect on 15th February 1991. CAM products are considered equal with pharmaceutical products for this legislation. The act requires any product that has therapeutic claims made of it to be entered into the Australian Register of Therapeutic Goods (ARTG). Its objective is to provide a national framework for the regulation of therapeutic goods and to ensure their quality, safety and efficacy. Australia is one of few countries that regulates to ensure safety, purity and efficacy of complementary medicines (Battaglia, 2003) and has the strictest regulation for complementary medicines as they are treated as drugs, whilst in other countries they are treated as foods (Blackmore, 2003).

The TGA is based on a risk management approach. In assessing the level of risk of a therapeutic good, a number of factors are considered. These include the strength of the product, side effects, potential harm through prolonged use, toxicity and the seriousness of the condition the product is intended to be used for (TGA, 2002). Low risk medicines maybe 'listed' products and do not have to meet the efficacy evaluation that high risk 'registered' products do. However the manufacturer of each product does need to hold evidence for any efficacy claims (Expert Committee Report, 2003).

The TGA assumes the suitability of one regulatory system for all medicines and deals with all agents from the same perspective. Supporting this approach MacLennan (1999) states that there ought not be any difference between regulation for conventional or non-conventional medicines, therapies or health foods. However the appropriateness of this has been questioned by Myers (2004) who suggests that the idea of a level playing field ignores fundamental difference between herbal and prescriptive agents including issues such as: mixed chemical vs. single chemical; native concentration vs. high concentration; long human exposure vs. new chemical entity; low safety profile vs. high safety profile: low side effects vs. high side effects; and often other benefits vs. sometimes other benefits. He suggests that as CAM, non-CAM, over the counter and prescriptive medicines are not playing the same game then perhaps the different substances ought to be treated differently, while still using safety, quality and efficacy as the bases for regulation.

Related to the issue of TGA are expressed concerns about the impact of the Codex regulations on food supplements, vitamins and minerals in Australia. Codex is an international body with more than 160 countries working together to develop and endorse standards for the international food code. As a member country Australia endorses the food standards that are set by Codex (Codex, 2005). However it is important to note that in Australia vitamins and minerals are classified and treated as therapeutic goods and thus come under the regulation of the TGA and not Codex (Truss & Pyne, 2005). This is distinct from countries that regulate vitamins and minerals under food standards and in these countries Codex would have an impact on these supplements. Although the Therapeutic Goods Administration assures CAM practitioners that Codex will not affect the CAM industry, it remains a concern for some (Blackmore, 2005).

Regulation of CAM practitioners

Regulation of CAM practitioners in Australia is an issue of importance for CAM practitioners and government bodies alike. In October 2002 the NSW Chief Health Officer released a discussion paper inviting submissions for the need to regulate CAM practitioners (Parker, 2003) and in October 2003 a discussion paper on the regulation of the health profession in Victoria was released (Carlton, 2003). In August 2006 the La Trobe Report was released. The La Trobe Report was initiated by the Victorian Government specifically for the regulation of naturopathy and Western herbal medicine (La Trobe Report, 2006).

Regulation is driven by the principles of public safety, the establishment of minimum standards and an effective system for handling complaints (Parker, 2003). However reasons for regulation are not the only factors to be considered when investigating the appropriateness of regulating an occupation. Another important factor is the 'National Competition Policy' (NCP). The impact of the NCP is observed by the amendment of the Health Act 1958 providing the Health (Amendment) Act 2001 (Carlton, 2003).

The primary aim of the NCP is to reduce anti-competitive conduct (Qld. Treasury, 2005) with the intention to encourage improvement in the productivity of the Australian economy and to improve living standards (Hilmer, 1995). The NCP seeks to remove unnecessary regulation measures (Pearson 2004) and encourages variety and choice (Parker, 2003) in the business sector. It requires that any new regulatory measure that might restrict competition first demonstrate that the benefits of the restriction to the community outweigh the costs, and that the objectives of the legislation can only be achieved by restricting competition (Doyle, 1998). Consequently legislative regulation by the Australian Government is done 'in the public interest' to maintain standards and protect the public (Carlton, 2003). In essence NCP promotes competition in the business sector unless it can be formally demonstrated that it is not in the best interest of the public (Hilmer, 1995).

Further there is an agreed process for the regulation of unregulated health occupation. The process requires the mutual agreement, by the majority of jurisdictions, that it is appropriate to regulate and then only if it can be demonstrated that there is a serious risk to public health and safety if regulation does not occur (Carlton, 2000). As part of the process there are six criteria for the introduction of statutory registration, with a key question being 'Is registration the most direct, effective and least restrictive way of dealing with a

significant risk of harm to public health and safety?’ Consequently one of the first criteria that must be met for statutory registration is a demonstrated risk to public health and safety.

If the need for regulation is demonstrated and the six criteria are met then the issues of regulation proceed to consider issues related to the principles of good regulation, as described in the ‘Principles and Guidelines for National Standards Setting and Regulatory Action by Ministerial Councils and Standard-Setting Bodies’ (COAG Publication, 1995) which require the minimising of public and administrative burden, accountability, compliance strategies and enforcement, amongst other things. Clearly the process of meeting the criteria for and the process of regulation is an involved task.

Statutory registration is not the only form of regulation. Indeed, there are six models for regulation of health professions in Australia, as outlined in Table II. Of these statutory and self-regulation are the two primary approaches used for registration of health care practitioners in Australia (Expert Committee Report, 2003). Many health care professions are regulated via statutory registration boards³, while others including complementary health professionals are subject to self-regulation (Carlton, 2003). Self-regulation is the preferred form of regulation for practices that do not carry a risk factor that ensures the need for statutory registration (Carlton, 2000).

Statutory regulation plays an important role in protecting the public and providing the feeling of confidence that registered health professionals are well qualified to do their jobs. It is noted that self-regulation can ‘go some way towards minimising risks to consumers of health service’ (Carlton, 2000) and for low risk practices has the potential to satisfactorily fulfil the role. Importantly all health professionals have an obligation to act professionally and provide high quality services to the public regardless of registration. Any unprofessional conduct of any health care practitioner can be reported to and acted on by the Office of Health Services Commissioner (Health Services Commissioner, 2005).

Carlton (2003) lists the key elements of an effective self-regulatory model as having a certification system; code of ethics; effective procedures for receiving, investigating and resolving consumer complaints; an established disciplinary system; incentives for

³ The powers and functions of a registration boards, of statutory bodies, are set out in legislation (Carlton, 2003)

compliance; strong institutional support for the system, from education institutions, insurance bodies, employer bodies and the Government; an effective public education campaign; and a cost effective regulatory structure that is financially viable.

Table II
The six models of regulation: used in Australian Health Care.

<p>Self-regulation - the model that applies to all Victorian health professionals that are not subject to statutory registration. Consumers rely on the practitioner’s voluntary membership in a professional association. Self regulation works best when there is ‘sufficient available sanctions within the industry to require compliance’</p>
<p>Negative licensing - a model in which anyone can practice unless they have been placed on a register of individuals who are not able to practice because of poor practice records.</p>
<p>Co-regulation - the model in which responsibility is shared between the industry and government. (Neither Negative Licensing or Co-regulation are actually used in Victoria).</p>
<p>Reservation of title only - in this model, particular titles can only be used by practitioners who are registered with the relevant registration board. This model is the primary model for Victorian health professions.</p>
<p>Reservation of title and core practices - both the title and core practices are legislatively restricted to appropriately registered and authorised practitioners.</p>
<p>Reservation of title and whole of practices – the most restrictive model for regulation. It makes it an offence for anyone to use the professional titles and to practice in the broad ‘scope of practice’ unless a registered practitioner.</p>

Sourced From Carlton, 2003

Alternatively the Australian Council of Professions defines an approved register for self regulation, as one with voluntary membership that is limited to individuals that: have a defined minimal qualification in both tertiary education and experience such that they can operate independently in their field of competence; adhere to a Code of Ethics and; are covered by professional indemnity insurance to the level required by legislation and provides for: competently assessed eligibility, using established criteria; access by the public to the list of currently registered members and ability to lodge complaints; disciplinary action for breaches of the Code of Ethics; a procedure for appeal by those

judged ineligible or liable for disciplinary action; access to a mediator or arbitrator to assist in resolution of disputes and; run by a “Registration Board” administered by the Professional Association (Professions Australia, 2004g).

Issues regarding regulation of practitioners

There are some concerns with self-regulation. Successful self-regulation relies on the professional group being highly cohesive and collegiate as it requires ‘sufficient availability of sanctions within the industry to require compliance’. As self-regulation is voluntary the option to not register may have no effect on business and thus little incentive to join. It is worth noting that ‘consumers rely on practitioner’s’ voluntary membership of the professional association as an indication that the practitioner is suitably qualified, safe to practice and subject to a disciplinary scheme.’ Further concerns relate to the risk of conflict of interest (Carlton, 2003).

To strengthen self-regulation it is necessary for the registration bodies to have benefits that are only extended to its members. Such benefits could include accreditation of training course at diploma (VET) or degree level; Traffic Accident Commission (Victoria) provider recognition; private health fund recognition; ‘recognised professional’ status for the purpose of GST free services; and eligibility under other government policies. To increase the likelihood of the Government endorsing a self-regulation framework the process for its establishment must be inclusive and have sufficient independent non-practitioners on the board (Carlton, 2003).

Parker (2003) states that CAM cannot have the benefits of regulation and still be a true alternative, that is be outside recognised and accepted health care. He notes that as scientific evidence accumulates, alternatives are likely to be integrated into biomedicine, losing their alternative status. Registration will mean practitioners will lose their status of being distinct from orthodox medicine, with boundaries blurring as insistence on evidence forces them to conform. This could be compounded as orthodox medicine appropriates treatments that are demonstrably effective, for example, as has occurred with acupuncture. It is argued that if CAM conforms to biomedical demands they will lose their alternative status. This raises the question, is it the ‘alternative status’ or what CAM represent that is the most significant issue at risk in the process of regulation and integration?

Expanding on this point, the importance of a health care practice maintaining integrity to its philosophical underpinnings is highlighted by Grant (2003b). Grant expresses concern with maintaining integrity when the regulation and training of CAM endeavours to fit into established system. In her article Grant (2003b) considers how to maintain philosophical integrity and address the demands and needs put upon the practitioners of CAM. She asserts we live in a materialistic, time poor society, with CAM endeavouring to fit into a dominant health system that is mechanistic and constantly seeking both time and economic efficiencies. She argues that while a practice needs to be economically viable, care and attention remain salient qualities of health care. Her focus is on the underpinning principles of the practice, rather than the 'alternative' status.

II Other Considerations

The Government has limited interest in the process of CAM development and its integration into the Australian health care system. Its primary concern is regulation for public wellbeing, where necessary. However the government also has other related considerations including the taxation system, the government's role in promoting CAM, the use of expert committees to investigate and deal with CAM issues in Australia, such as the Pan debacle and need for research.

Taxation and GST

With the introduction of Goods and Services Tax (GST) in 1999 the exemption of GST for health care services and selected medication impacted on the cost of CAM. Donohue (2003) states that with GST imposed on CAM products many Australians dropped CAM and turned to orthodox care and that with every dollar not spent on CAM self-care, Medicare and public health care costs rose \$4. Donohue noted that the investment in CAM provides a way to reduce current and future medical costs without any loss of quality of health.

It is suggested by Brighthope (2004) that the Government needs to look at ways to improve access to CAM as currently individuals who choose to use CAM, to look after their own health, are penalised. CAM professional associations are asking for more balance in costing to patients suggesting GST free services by registered approved CAM professional association practitioners. The associations also request GST free and subsidisation for

CAM products, at least for those items found to be as effective as pharmaceutical benefits scheme pharmaceuticals (Democrats, 2004). The argument is that the sale of CAM care products will provide the Government with cost saving in health care expenditure, with the benefit of a healthier community outweighing loss of revenue by taxing these products. It is noted however that some CAM services are GST free when provided by a recognised professional, for example herbal medicine and naturopathy (Department of Health and Aging, 2004).

That some CAM associations are asking for GST exemption for their members as ‘recognised professionals’ raises the issue of what is a ‘recognised professional’. The Australian Taxation Office (ATO) description of a professional association is an association that ‘has uniform national registration requirements relating to the supply of these services’ (Department of Health and Aging, 2004). It is important to realise that the Taxation Department’s definition of a professional association is not the only one and there are issues related to the differences in definition regarding the idea of a ‘recognised professional’ as will be discussed in Chapter Five. What is important to note at this stage is that beyond the idea of ‘national registration requirements’ the question is left open as to what are the suitable criteria and qualifications for the members of a professional association or recognised professionals for taxation purposes.

It is important to distinguish the different definitions and uses of the terms: professional and professional association. This point is demonstrated by the expressed concern over the taxation department acceptance of a wide range of organisations for the purpose of determining who could provide services GST free, over the possibility that this status may be interpreted as *de facto* recognition of these bodies (Expert Committee Report, 2003). The La Trobe Report expands the issue noting that this arrangement encourages fragmentation in industry regulation (La Trobe Report, 2006).

Finally the third criteria for a GST free health care service ‘the supply of that particular service would be generally accepted in the relevant health profession as being necessary for the appropriate treatment of the recipient of the supply’ may appear to indicate that GST emphasises the disease care aspect of the current health care system, as treatment is usually deemed to relate to the treatment of a defined diseased state. However appropriate treatment may be ‘to preserve, restore or improve the physical or psychological wellbeing

of the patient' (Aust.Gov., 2003a), thus the door is ajar for broadening the health care approach to include CAM modalities that promote health within the GST system.

Political promotion of CAM

The growth of CAM has attracted political attention and some Senators are suggesting CAM ought to be taken more seriously. Senator Barnett (2003) spoke on the benefits of complementary and preventative health care acknowledging the effort of leaders in the front line of preventative medicine in Australia. Barnett argued for increased research funding and the need to encourage consumers to take more responsibility for their health. He said that he could see benefits in establishing a 'Natural Health Care Advisory Council,' in Australia with the purpose of ensuring consultation and interchange between key stakeholder groups including consumers. Barnett also suggested that the government consider a cost benefit analysis, in terms of the potential savings from greater use of natural health care.

Further, the Australian Democrats have the integration of CAM into the health care system firmly on the agenda, arguing that the balance in the current health policy is wrong. The Democrats state that complementary health is a way to shift the balance in order to focus on health and wellbeing including preventative, early intervention and promotion of alternatives, rather than on acute care. They note that with so many Australians using some form of CAM, more than 40 private health insurance companies provide rebates on some CAM services and about two million complementary therapy consultations being conducted a year, there is increasing evidence of the value of CAM and the need to support increased public awareness of its effectiveness (Allison, 2004; Democrats, 2004).

At the same time this support is being promoted, other sectors of the Government talk in terms that are far less objective or open toward CAM. The web site scamwatch (2004) a joint Government and consumer protection agencies project, states a therapy is likely to be a scam if it claims (amongst other things) 'to be an alternative medicine, and provides no scientific evidence or demonstrated link between the cure and the effects of the product program.' The site goes on to use emotive language stating 'they are usually promoted by people without medical qualifications who cooked up phoney reasons why their products are not supported by conventional doctors' and 'are particularly nasty because they increase emotional stress, are costly and can be dangerous if they prevent you from seeking

medical advice.’ This approach is emotive and in contrast to the broader view acknowledging the value of CAM even if it does not as yet have adequate scientific evidence.

The Pan debacle

The incident known as the ‘Pan debacle,’ saw one of Australia’s major health food companies collapse. The incident involved the recall of millions of dollars worth of alternative health foods, complementary medicines and other goods made and/or distributed by Pan Pharmaceutical Limited. The surrounding publicity of the incident left many concerned, both in regard to the quality of the CAM industry and the impact of the incident on the industry. It resulted in the Government establishing the Expert Committee on Complementary Medicines in the Health System, to reassure the community and health care practitioners that the Government was taking steps to examine complementary medicines and their role in the health care system.

The committee was asked to consider what regulatory, health system and industry structures were necessary to ensure that the objectives of The National Medicines Policy⁴ were being met in relation to complementary medicines. The committee had their first meeting in June 2003 and recognised three fundamental principles as terms of reference for their report: the need to protect the public health and safety; the primacy of the right of consumers to be able to make informed choice on matters of health care; and the ethical responsibilities of all health care providers, from manufacturers to practitioners.

The Expert Committee submitted their report in September 2003 and the Government’s response to the report was designed to support confidence in the complementary medicines in Australia. The essence of their response was that they would follow the recommendations to strengthen support in the TGA’s continued role in supervising the quality and enforceable standards for complementary medicine, that they convene a stakeholders group to encourage innovation and research in complementary medicines, as well as to clarify the position of complementary medicines in regard to already established policies on the use of medicines, the ‘National Medicines Policy’ and the ‘National

⁴ which embraces principles of success, standards of quality, safety and efficacy, quality use, and a responsible and viable industry that are applicable to all medicines,

Strategy for Quality Use of Medicines'. The committee would also take action for the improvement of reporting adverse effects, including when used along with pharmaceutical medicines and access to reliable information for consumers, thus drawing complementary medicines further into the same requirements as for pharmaceutical medicines (Aust.Gov., 2005). The issue of safety related to the combined use of pharmaceutical and non pharmaceutical medicines and the importance of reporting adverse effects was further reinforced by the La Trobe Report (2006).

The La Trobe Report

The La Trobe Report was contracted by the Victorian State Government in June 2003 to consider regulatory requirements for naturopathy and Western herbal medicine, the report was released in August 2006. Amongst other issues it noted the challenges for consumers in navigating both the conventional and CAM systems when there is little communication between them. Increased communication and understanding between practitioners was recommended. Similarly the different philosophical approaches between practices were noted, as well as the need to improve access to accurate information and the potential to improve mainstream health care.

Importantly the Report found the arrangement of the modalities' professional associations weakened any united front they may have and that there was a lack of unity on the appropriateness for regulation. It was found that there was some concern that regulation would result in increased medical influence on the modalities. This concern was also expressed by some consumer participants (La Trobe Report, 2006). Overall the report recommended the process of regulation move forward.

United consultative council

Whilst Barnett (2003) recommends the establishment of a 'Natural Health Care Advisory Council' in Australia, Brighthope (2004) calls for the establishment of a Complementary Health Care Consultative Council to provide a link between government and consumers, health care practitioners, researchers and educators. Similarly Pearson (2004) calls for a National Health Authority that focuses on research, education and the integration of CAM into mainstream medicine and health economics. The development of some type of consultative council is considered an important step forward for CAM development in Australia.

Research

There is increasing calls for research into the efficacy of CAM and for the Australian Government to increase funding for CAM research (Expert Committee Report, 2003; Australian Democrats, 2004). Some natural therapy associations are lobbying the government for more funds for research with RACGP⁵ (2000a) and Australian Democrats supporting this request. Further Bensousann and Lewith (2004) assert that current research funding for CAM is inadequate and that the Australian Government has a social and ethical obligation to develop a research infrastructure. It is argued that it is important to encourage and fund adequate randomised placebo controlled trails of CAM (MacLennan, 1999) and the investing in high level clinical trials to assess the effectiveness of CAM therapies due to the number of Australians using them (RACGP, 2000a). While the La Trobe Report (2006) notes the importance of appropriately trained researchers for this important research.

Currently the Australian Medical Association (AMA) states that it is essential for consumers to have access to well researched information on CAM, so they are empowered to make informed choices and to question complementary therapists (AMA, 2004). Lewith (2000) asserts that physicians have a statutory and moral responsibility to conduct studies so that CAM can be safely integrated into medicine. He contends that this knowledge would allow consumers to make informed choices about the risks and benefits of treatments. This is representative of a medical profession not about to give up its advantage as the dominant provider of health care. In this approach accepting CAM and reinforcing informed choices translates to integration and a meeting of biomedical science based standards, requiring evidence and questioning of CAM practitioners. Importantly another perspective also presented by Lewith (2000) points out that when choosing their health care, patients may be looking for meaning and context, rather than proof of efficacy.

Kellehear (2003) points out complementary practitioners are expanding their interest in scientific research in order to provided evidence for their practice. However there is some debate regarding the appropriateness of evidence based medicine (EBM) with the suggestion that it is adversely affecting patient care by devaluing non-evidentiary aspects

⁵ RACGP, is the Royal Australian College of General Practitioners which is a respected and national leader in setting and maintaining standards for quality practice, education, training and research in Australian general practice.

such as clinical judgement and expert opinion (Dobbie et al in Grant 2003b). Indeed there is currently no evidence that EBM improves patient treatments and outcomes.

Grant (2003b) challenges the appropriateness of EBM for CAM on philosophical grounds. CAM has a tradition of empirical wisdom as a foundation for practice, while EBM has an apparent disregard for such knowledge (Dobbie et al in Grant, 2003b). Similarly Lipp (2003) points out the importance of distinguishing between evidence based practice and clinical effectiveness highlighting the need to consider the lived experience in health care.

Insurance and health rebate reforms

Despite forty-nine health funds around Australia providing rebates for ATMS services (Pearson, 2004) there are concerns that the Government will force Health Benefits reform and stop health rebates of some modalities (Ivancisk, 2003). However Cohen (2004) states that collaboration between doctors and CAM practitioners has been given a boost by the introduction of MedicarePlus package, which proposes an unprecedented rebate for allied health and CAM services when managed through the Enhanced Primary Care program. The provision of health funds rebates provides a source of recognition that is an important factor for CAM practices in the health care system.

Wellbeing Manifesto

On another angle the Australian Government strives for economic growth for improved quality of life using financial and intellectual capital to drive the production of tangible assets. Yet it has been noted that economic measures have failed to fully account for the quality of life, indeed the 'manifesto for wellbeing' (Eckersley, 2005) argues for national progress to be addressed in a manner that takes into account social wellbeing and national quality of life rather than only economic factors. Calls for inclusion of social capital, which is about national happiness- a less tangible value, in Government policies (Renzulli, 2002) are increasing and may assist the improvement of quality of life. Improved quality of life, wellbeing and thus health goes beyond economic viability despite the Government's current focus.

Summary

With the recognition that CAM is to be a part of the health care service in Australia the Australian Government is required to respond to this change. As the body responsible for the health and safety of the public the Government's primary role in the development of CAM in the Australian health care system is the regulation of CAM products and investigation of the need to regulate CAM practitioners for public health and safety. It is important to note that at a state level the issue of safety has to be balanced with economic issues. The Government also has roles in education, accreditation and research.

The Government response to the increasing demand for CAM was to investigate the need for regulation. TGA is held responsible for the regulation of all therapeutic goods however there is some question of the appropriateness of treating CAM products in the same manner as pharmaceutical products, due to innate difference between them. CAM practices, as with all practices, will only be regulated by the Australian Government when there is evidence of significant risk, due to a requirement to promote competition in the market place. When there is inadequate evidence for statutory regulation the Government encourages and supports self-regulation of CAM practices, as part of its role in promoting standards and public safety. This chapter has outlined the involvement of the Government in the development of CAM including aromatherapy in Australia. The next chapter will change direction to focus on aromatherapy as the sample CAM, with an overview of the historical development of aromatherapy practice.

Chapter 3

Aromatherapy

*At the end of the twentieth century,
the practice of aromatherapy appears to consist of
whatever the particular practitioner or user of the essential oils might make it to be.
Disjointed and scattered, it is practice without a theory.*
Schnabelt, 1999

The previous two chapters looked at the broad field of health and health care in the context of the increasing demand for and integration of CAM in health care. This chapter's focus is on aromatherapy as a sample CAM modality seeking professional recognition as a legitimate health care service. After an overview of aromatherapy's historical development the chapter will consider aromatherapy today, including its practice. Followed by an examination of what appears to be an identity crisis currently being experienced by aromatherapy practice as it seeks legitimation as a recognised health care practice.

I Aromatherapy's Development

Aromatherapy is 'the skilled and controlled use of aromatic plant extracts, essential oils, for the purpose of health and wellbeing' (Sheen, 2000). In many texts of aromatherapy it is said to have a history of thousands of years (Price & Price, 1999; Davis, 2000). Whilst, it is true that aromatic plants and their use have a long history, modern aromatherapy has a significantly shorter one. Modern aromatherapy is distinctly different to the use of aromatic plants (Schnaubelt, 1999). The term 'aromatherapy' was first used in the 1930's by Gattefossé (Cooke & Ernest, 2000), thus modern aromatherapy is around 80 years young.

Gattefossé is considered the founder of modern aromatherapy (Schnaubelt, 1999). He was born in 1881 in the French region of Lyon and died in 1950. Aromatic substances were part of Gattefossé life from childhood as his father and he, in turn, worked in the family's perfume business (Gattefossé, 1992). After 1906 Gattefossé began his systematic study of the essential oils looking at their chemical constituents. The use of the essential oils by local peasants as medicine contributed to his interest and stimulated his study on their medicinal properties. Gattefossé was both a cooperative worker and prolific writer. He worked with doctors, in hospitals and with a veterinarian, he produced soaps used to combat a 'flu epidemic and for wound care, as well as publishing numerous works (Gattefossé, 1992). His success in practice and publication resulted in his great influence on the development of aromatherapy. Gattefossé's book, 'Aromatherapy' published in 1936 still has a significant influence on aromatherapy practice today.

Gattefossé worked with the psychological and neurological effects of the essential oils and thus contributed to the holistic side of aromatherapy practice. However according to

Schnaubelt (1999) Gattefossé started aromatherapy squarely in the scientific paradigm with aromatherapy originating as a medical therapy based on the pharmacological effects of essential oils, considering essential oils as effective as conventional pharmaceutical drugs. Schnaubelt further states that Gattefossé's aromatherapy was biased to the reductionist methodology with its 'active ingredients' and 'treat the symptoms or disease' approach. Indeed there was no real distinction between aromatherapy and biomedical practice, essential oils were simply another medication within medical practice.

Dr Jean Valnet was another important figure in the development of aromatherapy in France. Also considered the father of modern aromatherapy, he revived and re-established aromatherapy after it had been forgotten for many years (Valnet, 1980). Valnet began his research in 1953, focusing on the application and dosage of the essential oils, as the effectiveness was well established by this time (Scott, 1993). Valnet began teaching in 1960s and conducted the First Symposium of Aromatherapy in 1960 (Scott, 1993). In 1980 he published 'The Practice of Aromatherapy' another aromatherapy classic. He continued the medical aromatherapy approach with his work being very similar to Gattefossé's approach (Schnaubelt, 1999).

Due to Gattefossé cooperative work and Valnet's dedication aromatherapy was recognised and adopted into the medical profession in France (Gattefossé, 1992; Cawthorn, 1995). According to Péroël and Péroël (1998) despite a brief lull in aromatherapy's development, today aromatherapy is a medical specialty with hundreds of French doctors and pharmacists qualified in phyto-aromatherapy (Péroël & Péroël, 1998). In medical aromatherapy the anti-microbial properties of essential oils are recognised and are the primary reason for the use of essential oils.

Meanwhile, the development of a claimed effective but harmless form of aromatherapy began with Marguerite Maury (1895-1968). Maury was a trained nurse and surgeon assistant who researched the essential oils extensively (Maury, 1989). She wanted a way to use the essential oils safely, for Maury this meant not using the essential oils orally. She believed the oral use of essential oils required a doctor and detersenised essential oils (Maury, 1989) as used by Gattefossé.

Maury (1989) focused on using the essential oils for rejuvenation rather than for medical conditions. She refers to rejuvenation as the restoration of the vital vigour, a better functioning (of the skin), normalisation of their inner rhythm (individual) and avoidance of the physical aging process (preferring maturity), where aging is the involuntary slowing of the rhythm of life and ability to adapt. Inhalation was her initial method of application however she also developed methods for skin application. She took her new style of aromatherapy to England where it was quickly embraced by the beauty and massage industry (Pénoël & Pénoël, 1998) and became known as holistic aromatherapy. Maury's classic aromatherapy text 'The Secret of Life and Youth' was first published in French in 1961 and then in English in 1964.

Robert Tisserand is yet another important figure in the development of aromatherapy, he was at the forefront of the development of aromatherapy in England. Being influenced by Gattefossé and Valnet he combined the medical approach with a more esoteric one (Schnaubelt, 1999). He taught aromatherapy and published the aromatherapy classic 'The Art of Aromatherapy' in 1977. This text played an important role in developing aromatherapy as a household word, as it made the concepts of aromatherapy accessible to lay people and drew in a wider audience (Schnaubelt, 1999). At this time aromatherapy began to be seen as a semi-medical modality that allowed the layperson to play a greater role in their health care. Schnaubelt (1999) points out that by taking aromatherapy from the medical world to that of the layperson a non-academic field of aromatherapy developed.

During the years between 1960 and 1990 aromatherapy developed rapidly. However it was in the 1980s that increased access to aromatherapy knowledge aided the process of aromatherapy's development. The easy access to essential oils and knowledge on their use is the basis of the popular aromatherapy used by the general public. Mackereth (1995) points out that the free availability of the essential oils and information of how to use them adds to the appeal of a 'safe and simple' therapy. By the 1980s aromatherapy had diversified into four basic areas: medical aromatherapy; massage based therapy; popular (self help) aromatherapy; and the scientific study of fragrance (Schnaubelt, 1999).

At the same time the popularity of aromatherapy was rapidly and extensively utilised as a marketing tool for many off the shelf products, everything from soaps to tissues were enhanced with aromatherapy, ensuring aromatherapy's commercialisation. Not only did

this increase the use of aromatherapy at home, but it is also said to have had a negative effect on the understanding of what aromatherapy practice is. Harris (2002) states that

'The popularisation, trivialisation and sometimes sensationalism created by the need to promote the therapy as a commercial product have masked and harmed the true therapeutic potential of aromatherapy.'

and

'perhaps in not distancing ourselves our inactivity is harming the reputation of aromatherapy as a whole'

He was asking aromatherapists to consider their role in the misunderstanding of what aromatherapy is. Aromatherapy is also used in the business world to create the desired environment. Morrison (2004) describes aroma as part of 'experiential marketing' used to maximise shopping behaviours, based on the idea that business is increasingly about the experience, rather than the traditional goods and service ideal.

In the early 1990s aromatherapy was found to be the fifth most popular complementary therapy in the UK, ranking below acupuncture, osteopathy, chiropractic and homoeopathy (IJA, 1993). Aromatherapy has been embraced by practitioners in a wide range of health care modalities (Nelson, 1997) such that in 1993 Tisserand (1993a) listed the modalities of aromatherapy as medical aromatherapy, nursing aromatherapy, holistic aromatherapy, aesthetic aromatherapy and psycho-aromatherapy. More recently, psychologists, social workers, chiropractors (Nelson, 1997), oriental medicine, kinesiology and veterinary medicine have extended the diverse selection of practitioners integrating aromatherapy into their practice.

On the other hand Price and Price (1995) assert the appropriateness of teaching aromatherapy as a discipline in its own right, without the addition of massage or other therapies to 'pad out' aromatherapy courses. Aromatherapists (Guba, 2003; Greenwood, 2003) claim that aromatherapy is a stand-alone therapy, but that it is also best used with another health care modality and that it does not have its own health framework but tends to be used along side other health care modalities.

In UK gaining statutory regulation is a primary goal for aromatherapists arguing that it is to safeguard both the public and the practitioner (Jenkins, 2001). To facilitate the process an Aromatherapy Statutory Registration Group (ASRG) formed (Smith, 2002), the body was charged by the Department of Health with the task of bring about the statutory regulation of aromatherapy. Difficulties in the process of regulation and requirement for unity were mention in discussions on self-regulation for aromatherapy in UK (Smith, 2003; Smith, 2004).

Nurses and aromatherapy

According to Cawthorn (1995) and Nelson (1997) nurses are increasingly using aromatherapy. Indeed in the UK aromatherapy is one of the most talked about complementary therapies in nursing (Mackereth, 1995) and aromatherapy is popular in many nursing care settings despite minimal research too support its use (Maddocks-Jennings & Wilkinson, 2004). Johnson (1995) suggests that one reason nurses have taken to aromatherapy is the similarity in philosophical basis. Similarities include: giving people control over their own health; taking a vitalistic approach and increased care; and moving away from the technical curative aspects of modern medicine, reflecting a holistic approach. Further, there are an increasing number of publications by nurses on aromatherapy and its use in practice and hospitals (Johnson, 1995; Cooksley, 1996; Cannard, 1996; Avis, 1999; Wiebe, 2000; Buckle, 2001; Campbell et al., 2001).

Indeed its popularity has increased such that professional accountability and concern about levels of training have become topics of interest in publications (Mackereth, 1995; Avis, 1999) with Rawlings and Meerabeau (2003) highlighting the need for policies and protocols to support implementing aromatherapy use in nursing. Mackereth (1995) suggests that to maintain their independence of work it is important for nurses to train in aromatherapy and be skilled in it, the same way they have gained skills in other areas, such as wound care. Further, he states this is also best for the patients as they have direct contact with the expert and the nurses can adjust the treatment as required themselves, rather than deferring to a consulting aromatherapist.

Avis (1999) draws to our attention the difference in aromatherapist and nurse approaches to aromatherapy practice and thus the need for different training levels and distinctions

between them. Rawlings and Meerabeau (2003) and Wilkinson (2004) noted that many nurses using aromatherapy are not formally trained. This is considered an issue for nurses who are required to practice within their level of competence (Wilkinson, 2004). Just what is an accepted level of competence for aromatherapy use in nursing is still an area of debate (Wilkinson, 2004). Clearly aromatherapy can easily be integrated into nursing practice, the issue is how.

Aromatherapy in Australia

Aromatherapy in Australia has followed a similar path as aromatherapy in England. Pamela Taylor is accredited with bringing aromatherapy to Australia from England in the 1980's. Trained by Archier a graduate of Maury, Taylor is said to have established the first aromatherapy course in Australia in 1985 (Cook, 2000). Other aromatherapists came to Australia about the same time, Greenwood (2003) for example, was teaching aromatherapy as part of her beauty therapist's course in the 1980s. Indeed initially aromatherapy in Australia was primarily attached to beauty therapy.

Medical aromatherapy was also introduced to Australia in the 1980s, when a French Doctor, Péroël started to practice medical aromatherapy in Australia. Guba trained with Péroël prior to his departure and continues to promote medical aromatherapy in Australia for non-medical practitioners (Péroël & Péroël, 1998; Guba, 2000). Both holistic and medical aromatherapy arrived in Australia in the 1980's. However, the appeal of the safe, effective and pleasurable Maury style aromatherapy has ensured that this style has been more widely embraced by practitioner and householder alike. At the same time the commercialisation of aromatherapy has clearly claimed a large market in Australia. One need only consider the successful 'Perfect Potion' stores and abundance of aromatherapy products on the supermarket, pharmacy and cosmetic shelves.

II Aromatherapy Today

In the twenty years since its formal introduction in Australia aromatherapy has grown from a fledgling beauty therapy practice to a proclaimed profession (Harris, 2002; Kirk-Smith, 2002; Thorne, 2002) in health care. White and Day (1991) claimed that Australian doctors are being converted to aromatherapy, while nurses use aromatherapy in the general

hospital, aged care facilities, for recovery from surgery, midwifery, oncology and palliative care. The use of aromatherapy by nurses in Australian hospitals today depends largely on the receptiveness of management and budget (Hill, 2003).

The practice

Today aromatherapy is seen to have a number of styles. There are three different orientations, five fields and three modalities listed in literature. The orientations of aromatherapy include the French style, which focuses on the medical use of essential oils; the English style of aromatherapy, which is also known as holistic aromatherapy a safer practice utilising massage and other topical applications of essential oils and; the German style of aromatherapy, the inhalation of aromatic substances. Tisserand (1993a, 1993b) listed the five fields of aromatherapy as medical, nursing, holistic, psychotherapeutic and aesthetic. The modalities of aromatherapy were described by Péroël and Péroël (1998) as regular aromatic care involving the daily use of essential oils; emergency aromatic care for physical and psychological trauma; and intensive aromatic care involving the repeated strong applications of essential oils for sudden and severe acute or chronic conditions.

Aromatherapists include those that focus on the massage or Maury style and those whom are using an aromatic medicine style (oral dose). At the same time other health care modalities integrate essential oil use into their practice increasing aromatherapy's association with other health care professionals. Ayurveda (Kerr, 2001a), oriental medicine (Mojay, 1996), nursing, massage, beauty therapy, and kinesiology are example of this association. The use of essential oils at home is also an important aspect of aromatherapy practice in Australia today. The range of the use of aromatherapy practice highlights its diversity.

It has been previously noted that aromatherapy practice tends to be across different paradigms (Sheen, 2000). Analytic reductionism, as physical interventions, is utilised in aromatherapy for the treatment of a condition or to stimulate the body's immune system. This approach is largely based on the pharmacological abilities of the essential oils. Schaubelt (2004) refers to this as the science of aromatherapy as he considers the components, pharmacology and neuroscience aspects of the practice.

The body mind approach of aromatherapy practice moves away from the purely physical reality acknowledging the role of the mind. It primarily looks at stress-induced effects and takes into account social and environmental factors (Sheen, 2000). This approach is described as holistic, however in practice it may simply be an analytic approach with the inclusion of more variables as the principles of practice are of the intervention approach of causal reality. True holistic principles may be used in aromatherapy for personal development work, the stimulation of the self heal mechanism and other health enhancing processes where outcomes are not predicted. The wellness approach promotes an empowering and holistic quality in the use of aromatherapy practice and embraces fitness and healthy lifestyle practices, used as a maintenance and preventative approach to health care, with self-care and ongoing personal responsibility key (Ryan & Travis, 1991).

The essential oils

Essential oils are the principle therapeutic agents in aromatherapy practice. They are defined as ‘volatile substances extracted by distillation or expression from a single botanical species. The resulting oil should have nothing added or removed during or after the process’ by the United Kingdom Aromatherapy Trade Council (Sheen, 2000). They are utilised in the food, cosmetic and perfume industries as well as therapeutic agents in aromatherapy practice (Sheen, 2000) and in some medicinal products.

As therapeutic agents their mode of effect is a critical issue both for determining effectiveness and appropriate use of essential oils. There are a number of asserted modes of effect of the essential oils. They can be grouped as the physical modes of effect or the energetic modes of effect.

Pharmacology deals with the interactions between living systems and molecules, especially chemicals introduced from outside the system (Katzung, 1992). It is a physical interaction based on principles of pharmacokinetics with dose dependent interactions based on Newtonian principles (Gerber, 1988). Pharmacological theories for the use of essential oils are expressed in a large number of books beginning with Gattefossé’s work and other more recent titles (Lavabre, 1990; Schnaubelt, 1999; Bowles, 2000). Pharmacological effects include biochemical or hormones/pheromones (Gumbel, 1986), terrain altering, neurological stimulation (Stromkins, 1998), mood altering and anti microbial effects (Sheen, 2000).

In aromatherapy practice the pharmacological approach may be seen as a primarily chemical one with the chemical constituents and their combination creating the therapeutic benefits (Bowles, 2000), or balanced with a view of the relationship between people and plants (Gumbel, 1986). The human / plant relationship includes the pharmacological approach however emphasizes humanising qualities and ‘chemical intelligence’ (Schnaubelt, 1999). It promotes a vibrational mode of effectiveness more in tune with homeopathic and shamanic medicine. Which can be observed in the view that ‘the oils (are seen) as messengers of energy and consciousness’ that use ‘psychological and spiritual “resonance”’ for ‘the unique healing force that it yields’ (Mojay, 1996) bringing us to the energetic approach to healing.

Energetically, in aromatherapy, Maury (1989) speaks in terms of the life force, Mojay (1996) considers the essential oils as messengers of energy and consciousness, while Lawless (1994) outlines different approaches. One energetic approach used in aromatherapy practice is ‘subtle energy’ which is described as ‘the movement of subtle, natural energies to manifest needed change’ which ‘isn’t necessarily directed toward healing (though it may be), and its aims are much broader’ (Cunningham, 1989). In aromatherapy texts modes of effect tend to be confused and intermingled possible due to an acceptance that biological and energetic healing intermingle, but just how that occurs is not clarified.

Recognised and valued application

The value of aromatherapy practice is an important consideration. Aromatherapy products have been listed in a review on complementary therapies, as including, diffusers, lamps, pottery, candles, pendants, earrings, shampoos, skin creams, lotions, bath salts, and shower gels (Barrett, 1998). This list is not describing what would be considered elements of a health care practice, but rather a cosmetic practice. With this kind of list it could be worth considering why aromatherapy has increased in popularity and how well aromatherapy is recognised as an option in health care. The use or ‘misuse’ of the term aromatherapy in the wider society could be an indication of the misunderstanding of what aromatherapy is, or an indication of aromatherapy practice’s lack of a clear definition and distinction from such uses of essential oils.

As an aspiring health care modality it would seem apparent that any therapeutic value of aromatherapy practice is what aromatherapists want greatest recognition for. The increasing use of aromatherapy in hospitals and by nurses may indicate that aromatherapy's increasing recognition is related to its therapeutic value. Yet aromatherapy is not necessarily as widely accepted and recognised as a health care modality as aromatherapists would like. In Australia aromatherapy practice doesn't enjoy the same level of popularity as in England. Research using a descriptive cross-sectional postal survey in 1998 of a random selection of 400 GPs in Perth showed that some GPs did refer to aromatherapy (Hall & Giles-Corti, 2000). However, it was found that aromatherapy received the least referrals of the ten listed complementary therapies in the survey (Hall & Giles-Corti, 2000), with massage being referred to over ten times more than aromatherapy.

In 1993 and 2000 a representative population survey of over 3000 persons 15 years and older was conducted by MacLennan and colleagues (1996; MacLennan et al., 2002). According to their findings individuals attending an aromatherapy practitioner had doubled between 1993 and 2000, but were still low with only 1.3 % of the respondents attending an aromatherapist in the 2000 survey (MacLennan et al., 2002). This is quite a small portion (5.6%) of the respondents attending an alternative therapist. However users of essential oils were found to be 15.3% (2002) being a larger portion of the number of individuals reporting utilising alternative medicines. However, whilst the study was about the use of alternative medicines there was no indication of a stipulation about how the essential oils were used, so this use of essential oils could be inflated by use for environment, pleasure or beauty, rather than purely for health care.

Pirotta and colleagues' (2000b) survey of Victorian medical practitioners found that of the 488 replies, 19 had trained in aromatherapy and 73 felt that aromatherapy was suitable for appropriately trained medical practitioners to practice. However three felt aromatherapy was frequently harmful, 215 indicated they believed aromatherapy was seldom effective, with only five believing it to be highly effective. At the same time 83 expressed an interest in training in aromatherapy and 67 felt aromatherapy was moderately effective. While there is interest in aromatherapy there is clearly not strong support for it amongst the medical practitioners in the survey.

Importantly within aromatherapy's own ranks we are reminded that aromatherapy does not have the recognition that aromatherapists want. Kerr (2001a) reminds us that aromatherapy has a long way to go to gain acceptance, quoting a magazine as stating 'don't expect more than a nice smell'. Jenkins (2002) emphasised the need to work hard at convincing the medical world of its worth, usefulness and efficacy. At least some aromatherapists acknowledge the lack of recognition, by the public and health care providers, for the effectiveness of aromatherapy practice.

Professional associations

Australia currently has two aromatherapy associations The International Federation of Aromatherapists (IFA) and Australian Aromatic Medicine Association (AAMA). Taylor established the Australian branch of IFA in 1985, with state branches developing progressively since. The IFA has a focus on aromatherapy and massage. While AAMA began as a break away association as a result of a desire for an association that was open to other forms of aromatherapy practice including medical and oral use of essential oils (Guba, 2000).

Training

The aromatherapy associations strive for greater recognition and set the current training standards for aromatherapy in Australia. In 2002 the IFA (Australia) aromatherapy training level had a minimum of 180 hours on aromatherapy, 100 hours on anatomy and physiology, plus 100 hours of massage and a first aid course (Simply Essential, 2002a). The AAMA has the same requirements with the exception that the 100 hours of massage can be exchanged for other modalities of health care. It appeared these were higher standards than other international aromatherapy associations at the time (ISPA, 2002).

However in Australia aromatherapy is one of many CAM therapies that are responding to the Australian government's development of a nation wide system of national vocational training. This system of vocational education and training accredits training for occupation employment and is an attempt to provide National Standards for workplace training. It is also a means to achieve government accreditation which provides a sense of recognition for

such courses and their occupations. This raises the same issue of *de facto* recognition as was mentioned by the Expert Committee Report (2003)⁶ for GST free status.

In September 2005 draft aromatherapy course outlines were considered for acceptance for recognised training packages by the Community Services and Health Industry Council (CSHISC), with three proposed courses: Certificate IV in Aromatherapy; Diploma of Clinical Aromatherapy; and an Advanced Diploma of Aromatic Medicine (CSHISC, 2005). In the first half of 2006 these courses were going through the second draft phase of development as they move toward becoming recognised courses meeting National Competency Standards as subsections under Complementary and Alternative Health Care. Indeed at least the first two courses are expected to be accredited before the end of 2006.

The courses, as in draft 2 form,⁷ have 17 competency units for the Certificate IV, 15 are compulsory with 5 being aromatherapy specific, and then two are elective which may be aromatherapy specific. The other 10 competency units are related to communicating, administration, first aid and occupational health and safety in health care. The Diploma has a prerequisite of 12 of the Certificate IV compulsory units, including the five aromatherapy specific units. It then adds a further 12 units, 10 of these are compulsory with four aromatherapy specialised units, the additional units relate to legal and ethical responsibilities and professional practice. The two electives units may or may not include further aromatherapy specific units. Thus the Diploma consists of 24 units, with nine to 11 of these being aromatherapy specific. The Advance Diploma is still being developed and is planned to have the Diploma as a prerequisite (CSHISC, 2006). It can be seen that the educational standard for aromatherapy training in Australia is expected to increase in content and thus hours with these accredited courses, however much of this increase is due to non specific training for working effectively in health care.

Knowledge

Turner (1998) refers to a group of CAM practices that have 'fragmented' from other therapies as 'sideliners'. He states that these sideliners generally lack the philosophical foundations and clinical skills required by the practitioners of the system they have

⁶ See page 37

⁷ This is referring to the second draft of the course and is thus only an indicator of the final accredited course/ qualification requirements.

'fragmented' from. He presents aromatherapy as one such practice noting that beauticians took it up without the comprehensive skills of a medical herbalist. Indeed generally aromatherapy is allied to another theory or philosophy. Aromatherapy, it seems, can be integrated into any other health care modality emphasising its versatility, but also its lack of its own philosophical foundations.

Aromatherapy lacks its own philosophy of health and disease, theory of aetiology, system of disease classification with consistent theoretical concepts and coherent diagnostic framework. As a practice aromatherapy relies on theories of health, illness and diagnosis from other health care frameworks. This does not mean it has no theories of its own for there are aromatherapy specific theories regarding the pharmacological and constituent of the essential oils developed by Gattefosse, Franchome and Péroël (Bowles, 2000; Schneubelt, 2003a) as well as energetic effects of essential oils. However, the constituent theories for essential oil effects have been criticised by Battaglia (1999) and Schnuabelt (2003a).

Against the constituent approach Battaglia (1999) argues for the importance of the whole essential oil, rather than the individual constituents opening the debate of the constituent theory's appropriateness for the practice of aromatherapy. Battaglia states it is a mistake to assume that if a constituent has a said effect on its own, that it will have the same effect in a whole essential oil. Indeed the constituent pharmacological effects theory is more seriously questioned when it is noted that therapeutic properties of essential oils vary despite having similar major constituents (Vickers, 1996). This debate focuses on the pharmacological effect related to individual components and the combined essential oil. It is moving into a debate of holism verse reductionism and can be argued as a weakness in aromatherapy's claim to be holistic therapy due to the tendency to lean toward the pharmacological effect of essential oils which is clearly analytic in nature and is tied to the practice's origins in the biomedical framework.

Aromatherapy practice's specialised body of knowledge is primarily based on traditional knowledge. Research on holistic aromatherapy practice is lacking, yet there is some analytic research demonstrating anti-microbial properties and psychological effects of the essential oils (Sheen, 2000). Some aromatherapists acknowledge the need for scientific research (Tisserand, 1995) to build a systematic and rigorous body of knowledge for

aromatherapy practice. However, concern has also been expressed regarding the development of scientific knowledge, legislation, ethics, and various methodological concerns (Sheen, 2000 & 2001). Maddocks-Jennings and Wilkinson (2004) point out that there is great potential for collaborative research by nurses. The theoretical framework behind the practice of aromatherapy tends to be full of paradoxes, neglected and in need of development. Schnaubelt (2003a) argues that for aromatherapy to come into its own it needs to develop a theory to explain and predict its effects. This approach would clarify aromatherapy as an analytic health care modality.

III Aromatherapy's Identity Crisis

Aromatherapy is said to be the skilled and controlled used of essential oils for health and wellbeing. In practice it is a term used to describe a number of different approaches to the use of essential oils and aromatic substances. From previous outlines it is clear that the question of 'what is aromatherapy' does not have a simple answer. King (1994) speaks of aromatherapy as a large and diverse enterprise covering everything from a marketing adjective for cosmetic products, to a serious branch of complementary medicine.

With such a diverse background and the fact that aromatics have been part of the cosmetic industry for so long it is quite understandable that the promotion of aromatherapy as a health care modality is challenging practitioners and organisations alike. That this challenge has been with aromatherapy for some time is shown by Roebuck's (1988) comments on the confusion and lack of clarity of what aromatherapy is. She further states that the media is adding to that confusion. With the same term used to refer to all forms of aromatherapy and no distinctions between the various styles, much confusion of what aromatherapy practice is can be attributed to this lack of clarity alone, such that Kusmirek (2003) states 'the term aromatherapy was so broad as to have little meaning.'

Moves have been made toward some clarification, for example in 1993 Tisserand listed modalities of aromatherapy and Péroël (1998) further assisted in clarification with his division of three approaches to aromatherapy. Despite these attempts there is significant confusion in literature on aromatherapy. Some authors assert it is strictly a health care modality (Roebuck, 1988; Bachbauer & Jirovetz, 1994) while others embrace the perfume

and cosmetic aspects (Kusmirek, 2002). Further some authors define 'aromatherapy' (Wheeler Robins, 1999; Bent, 2000; Kron, 2003) whilst others just use the term leaving the reader to work out which 'aromatherapy' is being discussed (Cawthorn, 1995; Cannard, 1996; Meyer, 1996). Despite the diversity of its application and the lack of clarity in the use of the term it is possible to refine and redefine what aromatherapy practice is. Questions that allow this include: Is it therapeutic and if so how? What are the application methods? What are the agents used? And what is the theoretical framework? Indeed these questions are areas of debate within aromatherapy practice today.

Today it is claimed that an aromatherapy massage, inhalation or bath is therapeutic for a number of medical conditions (Battaglia, 1995; Price & Price, 1999; Bowles, 2003). Alternatively some aromatherapists assert that the use of aromatherapy is for support only and not as a cure (Meyer, 1996). These different views indicate there is little unity on what aromatherapy as a practice is and can achieve.

Vickers (1997) argues that aromatherapy, if therapeutic, is only minimally so. Ernst, (2000) states there is indication that aromatherapy does have a transient effect on anxiety, but reminds us that there is no evidence of any long-term benefits. It is worth noting that when considering the question of efficacy, in literature, the focus appears to be on the massage style of aromatherapy. For this style of aromatherapy practice, it is questioned if the low dose of essential oils can really add any significant value to the massage (Lis-Balchin, 1997).

According to Kusmirek (2003) the original idea of aromatherapy was that essential oils improved mood or changed mood and therefore changed the individual's internal environment leading to an improved immune system. From this perspective emphasis is placed on the relaxation and de-stressing value of aromatherapy (Lis-Balchin, 1997). When Xingrean (Balacs, 1993) put forward the view that the therapeutic benefits of essential oils were entirely due to their relaxation effects Balacs (1993) expressed concern, arguing that other modes of action are also viable.

There is little if any scientific research to support most therapeutic claims in aromatherapy practice. However, there is strong scientific evidence (in vitro) of anti-microbial, anti-oxidant and pharmacological effect on various tissues (Lis-Balchin, 1997). Further there is

research demonstrating that aromas, including essential oils, can have effects on moods and behaviour (Ehrlichman & Halpern, 1988; Ludvigson & Rottman, 1989; Baron, 1990; Knasko, 1992; Warren & Warrenburg, 1993; Martin, 1996, Sheen, 2000). This indicates that the potential for therapeutic effect of aromatherapy practice is there, nevertheless strong evidence is lacking particularly for the popular Maury style of aromatherapy.

Continuing with the theme of minimal effect, Mackereth (1995) asks whether the essential oils and their use are of greater therapeutic value than the skills and presence of the therapist, suggesting that any benefit is due to the therapists rather than the aromatherapy treatment. King (1994) points out that the positive attitude of the therapist and appeal of natural product and religious feelings (peace, love, harmony) encourage faith in the treatment and enhance the placebo effect, which can be almost as effective as some drugs. Bent (2000) too questions whether benefits of aromatherapy are significant or simply placebo effects.

Lis-Balchin (1997) points out that there is a distinct difference in dose between two different styles of aromatherapy. Medical practitioners in France and Germany use large doses of essential oils in conventional medicine, while in UK and US diluted essential oils are used providing much lower doses. In Australia the lower dose use is prominent, despite little evidence that low dilutions (2% or less) of essential oils are any more effective than massage alone (Wilkinson, 2004). From a biological point of view, different doses are without a doubt going to produce different degrees of therapeutic benefits (Tisserand & Balacs, 1995). Indications are that the essential oils do have verifiable therapeutic properties. However using the pharmacological model the method of application and dosage of essential oils is likely to have a significant impact on any therapeutic effect. An energetic approach is likely to vary as well. Thus what methods of application are included in aromatherapy practice is important when making therapeutic claims. This directs attention to another debate in aromatherapy over just what application methods are included in its practice.

According to Buchbauer (1990) in aromatherapy the application method is strictly via inhalation. While Kron (2003) states that therapeutic application is via massage, inhalations, compression bandages and aromatic baths. And Roebuck (1988) states aromatherapy applications include inhalation, oral ingestion and on the skin (topical) use.

Tisserand and Balacs (1995) mention, dermal (topical), inhalation, oral, rectal and vaginal methods of application. The debate on oral use of essential oils was highlighted in the International Journal of Aromatherapy over the intention to teach oral use of essential oils in the UK (Price & Price, 1995). There is great diversity over what methods of application are considered safe and suitable for therapeutic aromatherapy practice. This has been related to level of training and causes a split between aromatherapy practitioners.

According to Grant (2003b) the philosophy of a healing practice is important both personally and professionally as it gives 'spirit and integrity' to our way of operating and plays a critical role in underpinning the art and practice of healing. Thus any healing practice gains greatly by having clarity on its philosophical foundations as well as a sound knowledge base. Consequently it would be helpful for theory to cover the philosophical aspects upon which the practice is based as well as providing a knowledge base for the practice.

What is needed is a theoretical framework that provides a platform from which aromatherapy can develop in a self-confident manner without constantly worrying whether outside authorities approve or not. The first element of such a platform is a clarification of the relationship aromatherapy has with science, (Schnaubelt, 1999 59-60).

Aromatherapy practice is regularly referred to as a holistic practice (Worwood, 1990; Battaglia, 1995) indicating that it has a holistic philosophical base. It is said to assist the body to balance itself so that healing may take place and is used as a natural alternative or complement to conventional medicine, embracing holistic healing through lifestyle enhancement, preventative and early treatment approaches (Cooksley, 1996). Yet aromatherapy is also clearly practiced as a conventional medicine (Battaglia, 1995; Schnaubelt, 1999) for when aromatherapy practice aims to treat a presenting condition it is utilising an analytically based approach. Also lifestyle enhancement and preventative practices can easily come under the wellness approach. Clarity of the philosophical base of its framework and the distinctions between the broad approaches in its practise is lacking.

Schnaubelt (1999) states that the tendency of aromatherapy to move from one paradigm to another in an attempt to gain acceptance from conventional medicine is counter productive. Schnaubelt (1999) refers to this as the vitalist, physicalist debate and it can easily be seen in the holistic verses analytic issue. Schnaubelt (2003a) notes the stark difference between the two paradigms is highlighted by the difference between the largely male advocates of scientific basis of aromatherapy and the largely female practitioners who tend more to intuitive, esoteric and holistic approach. He suggests that the tension between the two poles will assist with the further defining of aromatherapy (Schnaubelt, 2003b).

Summary

Aromatherapy is a diverse practice originating from a background of perfumery and medicine. It has branched out into many therapies including beauty therapy, massage and veterinary care. It has also been widely promoted and popularised as a form of personal self-care in cosmetic, wellbeing and health care uses. With aromatherapy knowledge and essential oils freely available to the public, aromatherapy practice is promoted as a safe and simple practice suitable for anyone to use. With so many approaches to the practice of aromatherapy it is obvious it is a socially constructed concept with multiple interpretations of what it is. It would appear aromatherapy is currently undergoing an identity crisis. What aromatherapy itself is and its value are important issues for the professional development of aromatherapy practice.

Historically aromatherapy has been used as a tool to enhance other practices. Nursing practice has shown interest in aromatherapy use. This is suggested to be due to a philosophical match between nursing and aromatherapy. As a tool aromatherapy practice's diversity is enormous and continues to grow. The scope of practice of aromatherapy is an ongoing debated issue in aromatherapy literature demonstrating a lack of unity in the practice of aromatherapy. Despite these issues aromatherapy practice is referred to as a profession with practitioner associations seeking greater recognition for the practice, setting standards and regulation. Which raises the question: is it appropriate to consider aromatherapy a profession? To address the question, what a profession is will be addressed in the next chapter, along with determining if aromatherapy fulfils the criteria of a profession.

Chapter 4

Professions

Professionalized activities, in fact, are based on a specialist expertise not possessed by the clients, who are usually unable to assess, both ex-ante and ex-post, the quality of the service that they have purchased.
Carillo and Zazzaro, 2001

In Chapter One and Two it was presented that the Australian health care system is currently in transition due to the demand for CAM practices. This time of change provides an opportunity for CAM therapies such as aromatherapy to develop in Australian health care. In the last chapter the history and practice of aromatherapy was described noting that it is referred to as both a health care modality and a profession. This chapter aims to examine if aromatherapy can legitimately claim to be a profession. It will review literature knowledge and concepts about professions including a historical perspective, criticisms of professions and their changing nature. The chapter will provide the foundational base for clarifying and understanding aromatherapy practice's current position as a profession or potential profession so that pathways for its continued development, its professionalisation, in Australian health care can be considered.

I Professions

Concepts about and definitions of what a profession is varies within the literature. Freidson (2001) points out that professions are an aspect of the specialisation and division of the work force, indeed, he states each profession is rooted in specialisation. Jackson (1970) describes the professions as a particular type of occupation which has characteristics apparently not shared with other occupational groups. While Freidson (1994) states that a profession refers only to the few occupations that are widely recognised as possessing very high prestige and a genuine monopoly over a widely demanded task, yet other occupations attempt to improve their prestige and economic position by referring to themselves as a profession. Elliott (1972) states 'The term 'profession' is widely and imprecisely applied to a variety of occupations'.

According to Cree (1995) whether an occupation is considered a profession or a non-profession depends on its ability to match the traditional professions of law, medicine and ministry, with a continuum from profession to non-profession. The comparison of other occupations to the traditional professions is done by extraction of the characteristics of the traditional professions and using these as criteria to be matched. This approach is referred to as the attribute approach. While there is much discussion on what the characteristic of a profession are there is some agreement on the core characteristics of a profession. The

emphasis of each characteristic varies with different models of a profession and the concise definition of a profession can vary as a result.

For the purpose of this study the focus will be on the definition of a profession as given by 'Professions Australia' and the criteria for defining a profession according to sociology literature. These definitions have been chosen because this study is specifically looking at professions in Australia and because

even without disseminating their analyses widely by popularization, the esoteric, specialized work of sociologists is sought out by others and if not taken as authoritative, then at least considered worth thinking about (Freidson, 1994; 21)

Definition of a profession

'Professions Australia' is a national organisation of professional associations that represents a coalition of professions in Australia (Professions Australian, 2004a) and promotes professionalism for the benefit of the community (Professions Australia, 2004c). It has 21 current members (Professions Australia, 2004b), a history of over 30 years and represents professions in Australia to the Government regarding such important issues as the Professional Standards Legislative (PSL) Regime (Professions Australia, 2004c). With this basis Professions Australia will be used as a guideline as to what a profession is perceived to be in the Australian market place. However it is worth noting that none of the traditional professions, medicine, law, clergy or academia are members of this association.

Professions Australia's definition of a profession is:

A Profession is a disciplined group of individuals who adhere to high ethical standards and uphold themselves to, and are accepted by, the public as possessing special knowledge and skills in a widely recognized, organised body of learning derived from education and training at a high level, and who are prepared to exercise this knowledge and these skills in the interest of others. (Professions Australia, 2004d)

Professions Australia's definition emphasizes a high level of trained knowledge and skills used in the interest of others, with high ethical standards guiding that use. When one looks at the criteria for membership more detail is obtained. Criteria for membership include: 1) having a professional body with substantial numbers of practitioners; 2) having specialised knowledge and skills to degree or equivalent level, applied to the service of the community; 3) recognition of a code of ethics, which should stress independence of practitioners, their responsibility (specified) and working in area of competence only; and 4) encouragement of continued professional development including knowledge and experience (Professions Australia, 2004e).

According to Professions Australia the important criteria for a profession are: the independence of the practitioners; their responsibility to only work in areas of their competence and continued professional development; along with recognized special knowledge and skills at the level of a degree; used in the interest of others with high ethical standard. This list of criteria for a profession can be summed up as: 1) responsible, ethical autonomy; 2) a tertiary level of specialised knowledge; with ongoing professional development; and 3) a service to and in the interest of members of society.

In sociological literature the core characteristics of a profession vary depending on the author listing them with some characteristics more generally accepted than others. In Table III a list of characteristics is provided from representative traditional and more recent sociology literature (Goode, 1969; Turner and Hodge, 1970; Illot & Murphy, 1999). Knowledge and dedication to service to the society are included in all of these lists. Freidson's (2001) ideal typical model is a slightly different approach he indicates knowledge and service as core characteristics, however he states that monopolistic control is the essential characteristic of a profession. Friedson's focus is on the profession as an occupationally controlled labour market with monopolistic control of that occupation's task and knowledge. He asserts the additional characteristics result from the need for control by the profession.

Cree (1995) states that the debate over the nature of professions highlights the reality that the term is not value free and neutral but carries with it special privileges, status and power. She states this is based on the idea that professional work is worthy of merit and carries

increased social standing, while non-professional work is substandard, inferior and is carried out by people of less ability or lower social class. Similarly, Weil (1988) states:

In an open society, professionalism has the power to confer upon its practitioners some of that same elevated prestige that might else where be obtained only by the accumulation of wealth or though aristocratic birth.

Table III

An overview of core characteristics of a profession: As there is some variation between texts on what the characteristics of a ‘profession’ are, a selection of texts on ‘professions’ were reviewed to highlight core characteristics of a ‘profession’.

Friedson 2001	Control	Knowledge	Service			
Goode 1969		Knowledge	Service			
Turner & Hodge 1970	Monopoly	Knowledge		Recognition	Organisation	
Illot & Murphy 1999	Control	Knowledge	Service	Recognition	Socialisation	Responsibility
						Accountability

Source: Created by the author from the noted texts.

Collins (1990) speaks of two models for professions. The continental model is directly related to state nobility. In this model the professions are the result of the replacement of a military state by an academic bureaucratic state, where those with appropriate education are employed by the state. These professional academics obtained a quasi-aristocratic lifestyle via their positions. European thinking tends to be in terms of class rather than occupation

(Freidson 1994). Professionals are of a class which confers prestige. The second model is the Anglo-American model. This model is based on the formation of monopolistic occupation groups operating a market for services separate from the state (self-regulated). According to Freidson's (1994) occupation theory the Anglo-American model is a knowledge-based model, it is where a body of specialised knowledge provides the bases of a recognised service to society and is monopolised by the occupation group. These two models for professions are related to knowledge and its use.

The Professions Australia definition uses the core characteristics of knowledge, service and responsible autonomy as characterised in literature. For this study a recognised body of knowledge requiring tertiary level training, an emphasis on service to society, and monopolistic control are the central criteria for classification as a profession. Other important characteristics include recognition, trust, risk, discretionary judgment, self-regulation, cohesiveness, ethics and the power engendered by the control.

Recognised body of knowledge

A profession is a knowledge-based occupation (Jackson, 1970; Freidson, 2001) requiring a high degree of generalised and systematic knowledge (Turner & Hodge, 1970; Ilott & Murphy, 1999). A profession's knowledge and skill must be officially recognised as based on abstract concepts and theories and requires the exercise of considerable discretion in its use (Freidson 2001). There is a strong and repeated emphasis on the importance of knowledge that fulfils a number of requirements for recognition as a profession.

A profession's knowledge needs to be organised into a theory, set of theories, or at least a complex web of theoretical orientations (Turner & Hodge, 1970). Being too complex and esoteric to understand spontaneously or to be learnt quickly it is considered beyond the average person (Freidson, 2001). Thus formal learning is required to master the knowledge and occurs over a period of time (Jackson, 1970) which in turn requires the student to make some significant sacrifices (Goode, 1969). Professions look to academic research for the theoretical core needed to validate their knowledge and they obtain official recognition through the institution of degree programmes (Elzinga, 1990). The complexity of the knowledge results in a quality of mystery distinguishing it from mundane things (Jackson, 1970).

Yet with all the complexity a profession's knowledge must be applicable to a real life problem encountered by most, if not all, individuals and deal with the problem or at the very least be believed to deal with it. A profession's knowledge is centred on 'problem-solving' ensuring a demand for it (Torstendahl, 1990). Indeed the high degree of knowledge provides a source of uncertainty for the client creating a level of 'indeterminacy' in which the client is unable to determine the quality of the knowledge and its use by the practitioner (Johnson, 1972; Carillo & Zazzaro, 2001). 'We respect those whose knowledge and skill seems to be right out of our range' (Howard, 1998). It is necessary for individuals to turn to practitioners of the profession to access the knowledge effectively.

Related technical skills are considered part of the knowledge base however it is the high degree of abstract knowledge and need for discretionary judgment that sets a profession apart from other occupations. Discretionary judgment is essential for the use of professional knowledge because each task is tailored to the individual's needs, rather than fitted to a standardised format. This relates to the professional ideal that one adapts the service or product provided to the needs of the client (Freidson, 2001). Further there maybe some risk related to the misuse of the knowledge and thus members of a profession have the responsibility of correctly using their knowledge.

Finally knowledge is specific to each profession with minimal overlap there is a 'privilege zone' of monopolised knowledge (Jackson, 1970). This ensures an exclusive and required activity for each profession ensuring practitioners opportunities to practice. Outsiders are considered dangerous (Jackson, 1970) for if they obtain knowledge it is moved from professional privileged knowledge to general knowledge. This would weaken the profession's knowledge base reducing the distinctive privilege aura of the profession. Freidson (1994) points out that knowledge itself does not give special power; it is only exclusive knowledge that gives power to its possessors.

As it is inevitable that knowledge will be 'leaked' it is vital to keep ahead. Each profession has the need and responsibility to keep their knowledge beyond the average person. As a consequence it is necessary for each profession to use its own resources to maintain its knowledge base by research, education and where possible legislation (Goode, 1969).

Consequently it is necessary for individual members of a profession to maintain ongoing professional development.

Service to society

According to Goode (1969) professional knowledge is dedicated to the service of society. Each profession has a service ideal which serves to inspire practice, constrain the practitioners, justifies privileges, provide cohesiveness within the profession as well as recognition and acceptance for the profession (Burrage et al, 1990). There are three aspects of the service ideal; first is the intention to serve others by providing solutions to clients' needs; secondly a service ideal that relates to a recognised and accepted higher goal or value of the society; and lastly the use of 'objective disinterest' by the practitioner which is considered an important quality of the service provided.

Traditionally the practitioner of a profession fulfils the client's needs without thought to their own needs or gains. To compensate for this commitment the professional community sets up a system of rewards and punishments (Goode, 1969). The idea that practitioners of a profession do the job for the satisfaction of doing a task and to provide a service comes from the historical aspect of professions when young nobles became members of a profession to provide the service. These nobles were able to serve in this manner because they did not need to earn an income.

Each profession lays claim to a service ideal or value and commits to serving that ideal above all else (Freidson, 2001). This higher ideal is deemed of value to, is accepted and recognised by the community at large and relates to a common issue for most, if not all people. Recognition of an occupation is connected to its value for the society and its ability to make a significant contribution to the society (Freidson, 2001). Examples of service ideals include justice claimed by the law profession, salvation by the ministries and health by the medical profession. It is a profession's high degree of knowledge that supports its right of service to a higher ideal.

In order to achieve the best results for the client, 'objective disinterestedness' is a requirement for task performance (Jackson, 1970). The idea is that the solution of the client's problem ought to be based on knowledge and facts and not on personal choice, either of the client or the practitioner. Thus the practitioner is required to take an objective

stance not allowing personal considerations either their own or the client's to influence their decisions, as it is not 'professional' for the client to impose their judgment (Goode, 1969).

Monopolistic control

Central to the ideal of service is that the task of the profession is to serve the client based on their needs, not the practitioner's. However as a profession's knowledge base is recognised such that it is used to grant authority to those in possession of it (Jackson, 1970). As a result a practitioner is able to claim that they are far more equipped to know both the problem and the solution, thus equipping them to decide on the client's needs (Goode, 1969). The client is required to listen and act on the advice of the practitioner, who may even violate the client's choice if it is deemed appropriate (Freidson, 2001).

Practitioners of a profession may make choices for clients, independent of the client's wishes, though faithful and reliable service is the normal claim for a profession's performance (Freidson, 2001). A profession's practitioner serves the client within the framework of the profession's service ideal (Jackson, 1970).

Autonomy of the profession itself is based on the idea of exclusive competence, that no one but the profession's own members are knowledgeable enough to either do the task or know if it is being performed well (Anderson & Western, 1976). Professions expect this autonomy and to set their own standards (Anderson & Western, 1976). There are three reasons given for a profession's autonomy: for the protection of members of the society, due to potential risk involved in practice; the setting of standards of practice; and protection of the profession's members, ensuring status and clients, thus income for the practitioners. There are two aspects to this autonomy: autonomy related to the profession itself, controlling the occupation, its knowledge, training, practice and regulation; and autonomy in regards to the practitioner's practice.

Autonomy requires legislation (Freidson, 2001) and this is unlikely to be granted unless the occupation can convince the appropriate body that they must trust the profession to do the task due to risk of harm to clients and or society by unethical or incompetent practice (Goode, 1969) and that the profession can and will control the work of the members, in the interests of the clients (Goode, 1969). There must be trust that members of the profession will do their task well and that they are accountable to society (Illott & Murphy, 1999).

Thus trust is an essential requirement for an occupation to achieve the status of a profession (Goode, 1969; Daniel, 1994). Knowledge becomes the bases of a power relationship in which the client trusts the practitioner to provide the required service and accountability plays a major role in the society's trust of a profession.

Members of a profession have a duty to fulfil this role of protecting the public by being trustworthy and accountable (Illott & Murphy, 1999). Often clients cannot measure performance well (helping professions in particular) and frequently even colleagues will have difficulty determining the quality of the service provided. Consequently commitment is used as an indicator of a practitioner's conduct (Goode, 1969). Further when essential behaviours are not observable there is a need for internalised controls and for colleague controls to be strong, when internal ones weak. Some form of self-regulation and inner discipline is essential to ensure that society is protected from misuse of the profession's privileged autonomy and trust. This in turn requires some cohesion in which these standards can be imposed (Goode, 1969).

Colleague control is performed by behavioural self-control following codes of ethics and conduct that are reinforced by providing advancement for those who uphold the codes and moral indignation and holding back work advancement if breach occurs. Or if the breach is extreme a practitioner may be struck off the registration, thus preventing them from practicing. Responsibility and accountability are key aspects of a profession and practitioners are legally responsible for their actions (Illott & Murphy, 1999).

Education of potential members is only by approved courses and examinations at institutions, properly organised and equipped for professional training. Once accepted into the professional school students are segregated from the ordinary market place (Freidson, 2001). Along with acquiring the profession's knowledge and skills, the students go through a process of socialisation that involves the inculcation of each student with the profession's ethics, code of conduct, professional identity, and where personal commitment is formed. These form internalised means of control of the profession's members.

Traditionally practitioners of a profession have a high degree of autonomy within their practice and were independent to make their own decisions as to what is the right thing to do. In practice today the level of autonomy is being deteriorated by the requirement to meet

organisational needs. With practitioners of a profession increasingly being employed by organisations they are submitted to a bureaucratic system of managerial control, which threatens traditional practitioner autonomy (Murphy 1990). As a consequence professions are changing in that previously they had more individual autonomy, with most practitioners working in private practice (Murphy 1990). Today a profession's practitioners are more likely to be employed within organizations and have less autonomy as they work within these organizations. Cree (1995) noted this less autonomy status for social workers stating that

professionalism in today's social work is of a different kind to that envisioned by the early social workers. It is not about either professional autonomy or independence. It is about following legislation and guidelines; collaborating with others; and respecting service users.

II Change in Professions

It is valuable to note that what a profession is seen to be changes over time and context. A profession has not always been seen as described above. According to (Elliott, 1972) in the pre-industrial era professions were relatively unimportant and occupied a niche high in the social stratification occupied by nobles not needing to earn a living. However the industrialisation of society and commercialism instigated a significant change. This change meant that by obtaining an education and becoming a member of a profession it was possible to obtain social status.

Over the past three or four decades other changes on views of the nature of professions have been instigated. Until the 1960s sociological studies of professions focused on the characteristics of the ideal model, the attribute or trait approach, and how an occupation became a profession (Grossman, 2003). At this stage professions were idealised as holding society together. However from the 1970s criticism related to specific characteristics of professions grew rapidly. Issues focused on the 'power' of professions and the questioning of the altruistic claims and of the knowledge base. Professions were no longer seen as an ideal that held society together rather there was concern of their potential negative impact

on society. Criticism of professions was such that in the 70s the decline of professions, including medicine, was predicted. However Freidson (1994) expressed the view that professions were changing rather than declining.

The most numerous criticisms of professions revolve around power (Freidson, 1994). Having been criticised for unjustified monopoly and privileges related to social closure; power in the form of authority over clients and associated occupations; and the defining of appropriate or 'norm' behaviour (Friedson, 1994). Indeed it is argued that professions conspire against the general public such that 'most critics of professions emphasis the plight of the client in the face of the professional' (Schudson, 1980). This plight is enabled by an acceptance of a profession's claimed right to intervene in personal and social problems 'we believe we are unable to deal with ourselves, fostering a dependence on expert knowledge' (Boreham et al, 1976). The power of professions has been argued from a number of views including patriarchy (Witz, 1992) and imperialism (Illich, 1973).

Illich (1973) acknowledges the value of a profession's knowledge whilst asserting it is used exploitatively, stating that at

first new knowledge is applied to the solution of a clearly defined problem and scientific measuring sticks are applied to account for the new efficiency. But at a second point, the process demonstrated in a previous achievement is used as a rationale for the exploitation of society by one of its self-certifying professional elites.

Thus he argues that the service of a profession quickly becomes a disservice and that political approval of this misuse of power is unjust. Similarly Murphy (1990) argues that professions use the ideology of service to advance their interests and that the quality of service is typically defined by that profession to suit its material interests. Jackson (1970) asserts that 'there is no reason to assume that professionals are either more charitable or more interested in their fellow men than others'.

Boreham, Pemberton and Wilson (1976) argued that professions were in a state of turmoil and crisis, involving both their intellectual foundations and their day-to-day practice. The

turmoil being directly related to the issue of whether or not a profession's knowledge actually solved the problem it is meant to or is beyond the average person. They assert that so called problems are created, posed and solved in the conceptual framework of the profession to provided work for the members of the profession and that a 'revolt of the clients' has developed with clients denying technical competence of experts and rejecting the legitimacy of professionals to interfere in their lives (Boreham et al., 1976).

Bertilsson (1990) argues that professions are changing as clients and citizens are increasingly questioning the practitioners of profession, moving from 'blind faith' questioning the bases of expert power and requiring 'justifiable reason' on the part of the practice and calling for accountability of scientific and professional practice. She relates this change to the development of citizenship and a call to seek out personhood. Bertilsson (1990) suggests that modern society has gradually closed the gap in status and power of the old professions. The principle of increased autonomy of individuals within the culture, with their growth and personal fulfilment is related to the personal power approach.

Grossman (2003) frames the question: 'would medicine still be a profession if practitioners lost much of their authority?' Returning to the question, asked thirty years ago by Boreham, et al. (1976) 'is the idea of 'client control of professional services' a contradiction in terms?' This question of essential criteria is important when considering the changing nature of professions. Which characteristics are possible candidates for change and which are stable requirements? In the previous section the core characteristics of advanced knowledge base and service to society have remained strongly emphasised in the idea of a profession. It appears that the authoritative approach to providing the service is the characteristic which most at risk of significant change.

Mowbray (1995) points out that professions, as institutions, have a philosophical base that is around control, causal reality and objective facts which involves the infantising of clients. He argues that occupations that are client orientated with the intention to empower the client related to meaning, increased autonomy, client efficacy and personal competence are philosophically at odds with professions. He states such occupations would have more integrity if they operated within institutions that matched their philosophical principles. Davis (1996) points out that sociologists have begun to propose 'new

professionalism' and 'democratic professionalism' as possible alternative forms of organisations in response to problems of professional power. This approach can assist realignment of professional values promoting new market philosophies that include emphasising client empowerment.

Finally Carillos and Zazzaro (2001) discuss the view that professions are said to reduce individuality and innovation due the requirement to conform, stating

professionalisation may hamper the innovative activity because it reduces the number of researchers that innovative sector may use since social status makes more attractive to work in already professionalized sector, even if it may give rise to a lower monetary reward, besides professionals may impede the rise of new professions derived from the innovative activity to protect their monopoly power.

The restriction on knowledge development ensures free thinking and new directions are curtailed.

III Professions Today

With the turn of the 20/21st century the idea of the 'profession' is being challenged, questions asked include: 'Do we need a new concept of what a profession is?' 'Is the professions' claim to authority and status an outmoded claim?' And 'What are the differences between profession ethics and business ethics?' Phillips noted that there was no modern definition of professions (Reece, 2003a). It has been suggested that professional values for the twenty first century need to be revised and thus promote the development of a new model of a 'profession' and 'professionalism'. The idea is due to interest in refreshing attitudes and practice in the old professions and to encourage discipline, excellence and a service ethics in the 'new' professions (RSA, 2004).

Today professions are a means to earn an income indeed it is argued that commercial pressures are such that there is no longer a separation between professions and businesses.

As part of the growing awareness of this change the issue of duality, that of protecting a profession's market position and the promotion of public service, is recognised and acknowledged (Grossman, 2003). Blind trust is no longer something that can be expected nor demanded by practitioners within a profession cum business. Reece (2003a) asserts there is a need to develop new ethical standards to deal with a series of inherent conflicts experienced working as a professional and that it is a healthy sign for consumers to test claims to professional competence.

Reece (2003b) argues that professional work driven purely by commercial pressures is harmful. She argues that it is necessary to ground professional practice in an ethical base regardless of commercial considerations, that there is a need to develop honesty, integrity, simplicity, equality and peace into the workplace. This stance requires ethical courage on the part of individual practitioners. She affirms the need for individual professionals to explore and clearly declare their values as part of the required action to re-invigorate trust in professions so they may be a significant and creative force for economic and social good. McGettrick (2002a) asserts that efficiency ought not be the only assessment of professions.

Professions need to be aware of their social context and operate for the common good, not driven by considerations of political expediency or the whims of the marketplace. In the market place the value of profit are placed above the values of people; and the values of the economy take precedence over the dignity of individuals and communities. (Reece, 2003a)

Fromm (1995) furthers this point stating that

the trend to look at measured outcomes alone has to be challenged. It has to be mitigated with evidence that comes from professional discernment. Evidence of care, compassion, beauty and so on is not best found in the domain of measurement

However concerns have been expressed on how to integrate this caring approach into practice, as there is no easy way to bring up caring without damage to conventional

understanding of competency of professional practice (Davis, 1996). McGettrick (2002a) asserts

I am advocating a society in which we can form people who will always act in the interests of the self and of each other. The professions have a duty to assist with this process.

Illich (1973) argues it is about choosing a life of action rather than consumption, a life style that enables spontaneity, independence and interdependence

The future depends more upon our choice of institutions which support a life of action than on our developing new ideologies and technologies. (Illich, 1973)

The authority and status of professions are being challenged by the public and governments that are more sensitive to public concerns (RSA, 2004) with the suggestion that a new model of professions and professionalism is required for the twenty first century. A model that is more suited to the current society. McGettrick (2002b) asserts that professions need to sustain the tradition of social trust and ethical practice, stating that ‘professionals serve beyond a functional capability, and touch the inner self of the society by their gifts.’

Professions and Professionals

Torstendahl (1990) reminds us that it is valuable to question our assumptions, including that of knowing what a professional is. There are a number of ideas of what a professional is for it is a term that is used quite loosely in the popular language. The adjective ‘professional’ is over worked (Elliott, 1972) being used to indicate someone who carries out their occupation at a high standard or is a member of a profession. Referring to a professional at least suggests that the quality of the work is higher than that of a non-professional (Howard 1998). Indeed professionals are expected to know what they are doing, to produce results, generally better than amateurs (Howard 1998).

However ‘professional’ is also a term used to refer to someone who earns money for their chosen activity rather than their doing that activity as a hobby. A practitioner of a profession is referred to as a professional, however ‘professional’ is more about the

practice which is reflective of the behaviour of a profession. The term 'professional' does not necessarily denote membership of a profession.

IV Aromatherapy as a profession

According to the literature, to distinguish 'professions' from other forms of occupations the core characteristic of a traditional profession are used. Grossman (2003) describes two difficulties with this attribute approach: first, that of distinguishing essential and accidental attributes; and secondly the confusion between a descriptive definition, stating what was required and a normative definition referring to ideals aimed at.

The first difficulty is observed in the wide range of variation in stated characteristics of a profession as noted early and the basic question of which ones are essential. For this study the core characteristics have been determined via both current market place and literature views. The second issue relates to questions of the characteristics that a profession requires and those that it ought to pursue and realise, acknowledging an occupation could be a profession whilst still pursuing the ideal. This provides the opportunity for an occupation to be considered a profession prior to reaching the idealised view of a profession.

Despite the issue of the changing nature of professions the attribute approach is still utilised to determine which occupations are considered a profession as indicated by the current market place definition utilised. Thus core criteria earlier noted will be used to determine if aromatherapy could currently be considered a profession. The core criteria being: a recognised body of knowledge requiring degree level training; an emphasis on service to society and service ideal; and autonomy via monopolistic control.

The Knowledge base of Aromatherapy

To determine aromatherapy's standing as a profession we first consider how well its knowledge base fulfils the criteria of a profession's knowledge base. Currently the requirements of professional knowledge can be listed as specialised and monopolised knowledge that has a recognised and valued application, consisting of developed theories and concepts, requiring discretion for its effective use and extended formal learning at a tertiary level qualification.

In regards to the level of training the current Australian aromatherapy association training level and training packages proposed for recognition are at certificate and diploma level. Whilst there is potential for aromatherapist to upgrade their training to tertiary degree level the specific aromatherapy knowledge component does not form a large portion of the training. Importantly aromatherapy is increasingly associated to other health care professionals in particular nurses and massage (Vincent & Furnham, 1997) emphasising its versatility and its lack of comprehensive knowledge base. That aromatherapy knowledge is freely available undermines monopolisation of the occupation's knowledge base.

Aromatherapy's service ideal

A profession's value is the occupation's ability to make a significant contribution to the society (Freidson, 2001). This contribution must be recognised and valued by society at large and the increase in aromatherapy's popularity can be used to indicate the recognised value of aromatherapy. However while aromatherapy lays claim to providing a service in health care the diversity and lack of clarity of its service is such that it has resulted in an identity crisis for aromatherapy and opens the possibility that the growth is not related to the health care use of aromatherapy. The question of 'what service does the practice of aromatherapy provide to the society?' is left, at best unclear. It is also important to note that the service ideal of 'health care' is already claimed and to attempt to claim it ensures challenges from the already established profession in the field.

Aromatherapy's monopolistic control

A profession's autonomy and control is directly connected to control of its knowledge base and having a recognized and valued service related to that knowledge. Aromatherapy's knowledge is regularly shared with other health care professionals, including training them with specially designed courses (Simply Essential, 2002b). Further the mass production and popularity of aromatherapy texts ensures lose of control of the knowledge. Specialised knowledge on aromatherapy is freely available and not monopolised.

In Australia primarily approach to aromatherapy practice (holistic) is promoted as a relatively safe practice. As a consequence the idea of monopolisation on the grounds of protecting the public is contradictory to the public promotion of the practice. Indeed it is questionable that there is adequate risk associated to the use of aromatherapy knowledge or practice to reinforce the need for autonomy for public protection.

Aromatherapy is not a profession

Evidently the answer to the question ‘is aromatherapy a profession’ is no, aromatherapy does not meet the criteria of a profession according to the definition outlined. However this does not mean that aromatherapy practice cannot meet them in the future, nor is it indicative of aromatherapy’s interest in meeting the criteria by professionalising. Indeed as aromatherapy is attempting to control the disseminating and application of the knowledge by recruitment, training and registration via establishing professional organisation and standards there is indication of an attempt to professionalise.

Summary

Definitions of what a ‘profession’ is vary within literature and have been noted to change over time. Indeed it is argued that there is not a modern definition of what a ‘profession’ is today. Consequently the definition used in this study has been established from commonality between various sociology literature and current Australian market place definitions. With the core characteristics of a profession determined to be: a recognised body of knowledge requiring degree level training; an emphasis on service to society with a service ideal; and autonomy via monopolistic control.

Using this definition of a profession the practice of aromatherapy does not meet the criteria and thus is not considered a profession. As there is indication that aromatherapy associations are beginning the process of professionalisation the next chapter will examine the professionalisation process. This will provide a base to consider what the aromatherapy industry would need to do to become a profession in the Australian health care system.

This chapter also noted that despite the high status of professions there are challenges directed at this class of occupation. The primary issues being: the ‘power’ of professions; questions regarding the claimed need to protect the ‘individual’; and a lack of distinction between professions and businesses in the current market place. These issues have resulted in calls for greater ‘accountability’ and new ‘ethics’ and arguments that efficacy ought not to be the only form of assessment. Consequently it is suggested that an authoritative approach may no longer be an essential characteristic for a new definition of a profession.

This potential change can be seen as especially important if philosophical issues for both the new ideal of a profession and holistic CAM practices are aligned.

Chapter 5

Professionalisation

Professionalisation has been, and still is, a process that has profoundly influenced the economics of the most industrialized countries.

Professionalisation entails a radical transformation of the whole occupational system, since it gives the members of occupations characterized by a high degree of generalised and systematic knowledge the authority to decide whether or not to admit a potential recruit, to control the behaviour of those who belong to the profession and a monopoly power on the market for the professional services.

Carillo and Zazzaro, 2001

As indicated in the previous chapter aromatherapy practice currently does not meet the criteria of a profession as determined from the literature. The occupation may nevertheless tackle the professionalisation process in an attempt to obtain the status of a profession and or the status associated with it. This chapter aims to provide an understanding of the professionalisation process to enable discussion of professionalisation in regard to aromatherapy practice. The chapter will consider the general process required for professionalisation further examining the literature on professionalisation. Finally some examples of specific occupations and their professionalisation aspirations will be reviewed in order to demonstrate specific issues embedded in the professionalisation process.

I Professionalisation

The process by which an occupation moves towards and if successful becomes a profession is known as professionalisation. According to Collins (1990) there are many different pathways for professionalisation, yet the process is one of attempting to fulfil the criteria of a profession. As outlined in the previous chapter the core criteria for a profession are a suitable and accepted knowledge base, service to society and monopoly over the occupation's knowledge and practice.

Professionalisation evolved as part of the industrial revolution (Parsons, 1972) and the corresponding growth in demand for expert services (Perkins 2003). Hughes (1958) notes it is common for an occupation to attempt to step up the occupational hierarchy by turning into a profession. Indeed an increasing number of occupations wish to obtain the status of a profession to improve their status power. As a consequence some occupations such as pharmacy, dentistry and clinical psychology have been accepted as professions (Goode, 1969).

Goode (1969) notes that despite the fact that the process of becoming a profession has a tendency to be difficult for many occupations aspire to the status of a profession. Some occupations make significant progress toward becoming a profession yet do not fulfil enough of the criteria to become a 'profession'. According to Goode (1969) these occupations are referred to as 'semi-professions'. He points out that almost no occupation has risen from a low occupational rank to the top rank of a profession, asserting it is more

common for an occupation destined for professional status to appear fairly high in status and rises from there. While a low ranking occupation is more likely to become a semi-profession.

Semi-professions

A semi-profession is an occupation that almost reaches the status of a profession but is held back by an aspect of the occupation that prevents it from fulfilling the criteria of a profession (Goode, 1969). Torstendahl (1990) speaks of these occupations as being dismissed as semi-professional which means that they fall short of the standard set by the ideal-typical profession. Beckman (1990) describes a semi-profession as an occupation that is between the two occupation types of skilled labour and profession. Where a profession has autonomy and skilled labour does not, however both require substantial formal training (Beckman, 1990). According to Freidson (1988)

The semi-profession is an occupation that has gained jurisdiction in a division of labour market shelter and has control over its training, credentialing, and supervision. However, it has not established sufficient cognitive authority to dominate either the division of labour in which its jurisdiction is located or public discourse concerning its work.

He also refers to such occupations as para-professions.

Simpson and Simpson (1969) argue that there are distinct differences between a semi-profession and a profession, stating that there are two traits that are indicative of a semi-profession rather than a profession: lack of autonomy and a humanitarian approach. These qualities are counter to the monopoly and authoritative approach of professions. Similarly Hughes (1958) states semi-professions provide client based activities.

According to Simpson and Simpson (1969) the semi-professions desire to provide a humanitarian service is driven by an emotionally felt urge to give and to relate in a personal manner. Practitioners of semi-profession address the client as a person and develop a relationship with them. This is in opposition to a profession's ideal of 'objective disinterestedness' in which it is inappropriate for subjective considerations to influence the

task and outcome. Simpson and Simpson (1969) describe this difference as ‘holistic’ and ‘task’ approaches. This difference also relates to differences in the practitioner rewards in the humanitarian approach the reward is in providing the service and relates to the desire to be sociable, while a profession’s practitioner reward is the application of special skills to a special problem, the task itself.

As an example the health ideology sector demonstrates the described differences between semi-professions and professions well. In health care doctors are the dominant profession with nursing the related semi-profession (Jackson, 1970). The doctor is said to have mystical autonomy, determines the treatment for the ‘case’, while the nurse deals directly with the patient and applies their knowledge in a profane manner which may include providing supportive education for the patient (Etzioni, 1969; Jackson, 1970). The doctor’s knowledge is considered greater than the nurse’s and nurses defer to the doctors. Doctors tend to treat the patient as a case, while nurses interact with the patient and develop relationships.

Why professionalise?

If the process of professionalisation is such a difficult path and so rarely successful, the question of what motivates an occupation to professionalise is one of significance. Hughes (1958) asks ‘What are the circumstances in which the people in an occupation attempt to turn into a profession and themselves into professional people?’ He states that motivation to professionalise is driven by a desire for more recognition, prestige and income. Similarly Carillo and Zazzaro (2001) state that the leadership of an occupation deliberately pursues the professionalisation process to create a market for their service, to maintain and increase social status and to obtain monopolised power. While Collins (1990) refers to professionalisation as a struggle for power by the formation of self-regulation and indicates that it is seen as key to success. Prestige, power and income are seen as significant motivation for attempts at professionalising.

Alternatively Morrell (1999) perceives the professionalisation process as being market driven, with a natural sorting of providers into ‘good’ and ‘poor’ in terms of the service provided. He suggests it’s about distinguishing the quality of the practitioners, setting standards for practitioners and ensuring safety for clients. It has also been pointed out that some occupations may require professionalisation in the sense of higher standards of

intellectual rigour or integrity or better systems of training, inspection and regulation and that there are occupations for which professionalisation maybe inappropriate (RSA 2004).

II Process of Professionalisation

Hughes (1958) states 'it is assumed that the claims of professional status are themselves *the* major conditions for professionalisation', indeed this is not the case for an occupation needs to go through the process of obtaining all the characteristics of a profession (Turner & Hodge, 1970; Harris-Jenkins, 1970) to obtain the status of a profession. The characteristics of a profession outlined in the previous chapter are used as criteria for analysis of the degree of professionalisation. Each occupation follows its own unique pathway in the professionalisation process (Collins, 1990). Consequently rather than focus on the process itself it is more valuable to look at the components of the professionalisation process and the degree of professionalisation related to these.

Service, knowledge and monopoly in the professionalisation process

As part of the process of professionalisation an aspiring profession must clarify and consider its higher ideal, its service to society. The ideological service or social value is so essential to the process of professionalisation that it is required to begin the professionalisation process (Burrage et al., 1990). It is important to take care to distinguish an aspiring profession's service from an established profession's, as well as to develop one that will be recognised and accepted externally. For it is more likely for a profession to rise if it has its own service ideal and is making a valued contribution to society (Burrage et al., 1990). An important part of the professionalisation process is the need for an occupation to distinguish itself from others (Cree, 1995), to establish its uniqueness.

The development and monopolisation of a knowledge base that is valued and provides an area of uncertainty is a critical aspect of the professionalisation process. According to Jackson (1970) the process of professionalisation can be seen as a process of increasingly defining protective boundaries, with success dependent on their control of an area of uncertainty (Collins, 1990). Thus the extent to which an occupation has separated itself from other occupations in order to establish an area of uncertainty or 'indeterminacy' can be used to indicate the degree of professionalisation.

It is essential that an aspiring profession develops a critical attitude toward its existing theoretical systems. The degree of professionalisation can be assessed by the extent to which the occupational group encourages research into its work activities and refers to research designed to produce valid new theories to serve as the basis of improved operational techniques. Indeed continual development of the knowledge base reflects an awareness of the requirement to maintain a high level of knowledge and indeterminacy.

This process of monopolising and defining boundaries is described as a process of 'closure'. Morrell (1999) speaks of four phases of the process of closure: laissez-faire where anyone is able to practice in the field; the development of association, beginning the process by providing the framework for registering practitioners; a stage when registered practitioners dominate non-registered practitioners; and closure where only those suitably qualified and registered are able to practice, at which stage monopoly of the practice is obtained. The stage of 'closure' is also an indication of the degree of professionalisation that has occurred.

Actors in the professionalisation process

In considering the degree of professionalisation of an occupation it is important to look at all the actors influencing the professionalisation process. Each actor is a group or organisations that have a role in the process and are listed as the practitioners, the occupation's (professional) association, the users, the public, the universities, the state or governing body and other professions (Turner & Hodge, 1970; Burrage & Torstendahl, 1990). Relationships with the state and other actors are extremely important for an aspiring profession, cooperation as recognition and trust are essential for obtaining the status of a profession.

Practitioners are central to the occupation's development. One of an occupation's first steps toward professionalisation is the uniting of practitioners and the creation of occupational organisations. To enable the formation of an organisation there must be an ideology and commonality. Commonality in the ideology supports the required unity, plays a key role in the establishment of an occupation and provides for both internal cohesiveness and external recognition (Burrage et al., 1990).

Once established an occupation's organisation plays a vital role in the process of professionalisation. Occupational organisations tend to have a focus of one or more of four general goals related to: the knowledge base; representation for legislative relief; negotiation on behalf of the members; and qualifying or regulation of members (Burrage et al., 1990). Burrage et al. (1990) distinguishes a professional organisation from other types of organisations by persistence and proximity. Persistence relates to the stability of the profession's ideology goal over time. Proximity relates to the assertion that the practitioners themselves know the knowledge of the professional practice best and thus any attempt to change or control the professional behaviour requires consultation with the profession itself. According to this view a professional organisation or association must have a stable ideological goal and assert that they are the only ones knowledgeable enough to control the practice.

Professional associations have many roles in the professionalisation process, they represent the occupation including promoting the profession to the community, to state and insurance companies. They often act as pressure groups that form alliances with other power groups, such as government and courts of justice, in order to obtain privileges and thus enhance the status of the profession (Carillo & Zazzaro, 2001). Significantly they have an important role in setting industry standards, codes of ethics and conduct, the registration of practitioners and educational institutions. In effect they promote the industry and play an important role in the closure process by providing the structure to monopolise and control the occupation's knowledge and practice.

Professions Australia (2003) assert that 'Professional associations are continually under pressure to provide value for money. Rightly so.' Practitioners want value for money and are not likely to become members of an association if they see no value in doing so. Importantly, an association has to represent a large portion of practitioners to have the power to enforce registration and monopolisation thus they need to provide the practitioners with a value for money service to encourage their membership and support.

Along with the degree of closure there are two general approaches for assessing the occupations' organisations: the community approach and the formal organisation approach (Turner & Hodge, 1970). The community approach focuses on the qualitative aspects of the relationships among the members, such as the sense of community, sense of identity,

common values, duration of membership and self-propagation, via selection and education. While the formal organisation approach focuses on organisational mechanisms and techniques (Turner & Hodge, 1970) this deals with the enumeration, registration and licensing of competent professionals. Analysis can include examining both of these aspects.

As actors in the professionalisation process the users of a professional service and the general public can be grouped together. The users of the profession are the backbone of its practice, without them there would be no need for the profession. There are various types of users of a profession, these include: individual fee for service; third party paying organisations (ie unions); the state, the dominant third party payer; private employer; and public employer (welfare state). Each type has different requirements of an occupation's task and thus requires different responses from the profession.

As actors in the professionalisation process the universities or educational institutions control the dissemination and development of a profession's knowledge. Thus they are of central importance to a profession obtaining and maintaining its professional status. However universities are also a potential source of conflict between practitioners and academics. This is because of the different roles and expectations of each. The practitioners want a stable body of knowledge and tend to keep complaints to themselves, while academics disseminate the knowledge to the widest possible audience, focus on the continuing development of the knowledge base and academics will seek public and state opinion on issues of debate. Finally when the state has empowered a university to train the practitioners, the state gives the professor a higher status than practitioners (Burrage et al., 1990).

The state or governing body is either directly or indirectly involved in every aspect of a profession, the education, licensing, registration and even marketing (Burrage et al., 1990). Thus the policies of state have a profound impact on a profession and those occupations partaking in the process of professionalisation. Significantly each profession is dependent on the state for its autonomy for it is only the state that has the power to grant autonomy. The state will not legislate without a need, therefore any developing occupation needs to convince the state there is a need for this step.

Finally other professions play a significant role in the professionalisation of an occupation. Established professions are in a position of power and can support or undermine the potential of a new profession simply by acknowledging their value or discrediting them. That is, the value of aspiring occupation needs to be conceded by established professions, especially the closely related ones (Goode, 1969). Thus, if aspiring occupations establish their value and credibility to related professions in a non-threatening manner, it is easier to obtain recognition by the public and potential users. Competition between occupations can lead to members of a group to aggrandise themselves (Goode, 1969) providing a source for an established profession to discredit them. Consequently it is not likely that a new profession will develop at the expense of another profession, it is more likely to be via contributing more to the society (Goode, 1969).

III Examples of the Professionalisation Process

By looking into the professionalisation process of a selection of occupations, issues of the professionalisation can be noted clearly. This, in turn, allows for a realistic understanding and appreciation of the process. Medical practice will be considered specifically regarding monopolisation strategies, whilst nursing practice demonstrates the need for a distinct service ideal. The recent progress of Traditional Chinese Medicine (TCM) occupational development shows the need for risk. Counselling on the other hand points to the need to have appropriate knowledge base, demonstrated effective practice associated to training and matching philosophical principles. Members of the counselling occupation also introduce anti-professionalisation views promoting an empowering humanistic philosophical base and a need to consider the appropriateness of professionalisation for the occupation.

Mediation is an example of an occupation that considers the need for a unique knowledge base and it reframes the lack of indeterminacy into the empowering framework. The occupation promotes a client's ability to determine for themselves who provides an effective service and questions the appropriateness of the professionalisation of the occupation. Finally the professionalisation of coaching suggests the need to be aware of the requirements and challenges of professionalising today.

Medical Practice

Medical practice is one of the traditional professions and today's authoritative expert in health care. Medical knowledge is well established, has an officially approved monopoly and is considered definitive with the right to define health, illness and its treatment. As a traditional profession medical practice provides an example of the professionalisation process demonstrating how an occupation has taken over a service ideal, monopolised it and provided resistance to similar occupation's development in the monopolised area. It also demonstrates adaptation to public demand by the limited integration of similar occupations in order to maintain its dominance and monopoly. In the public mind medical practice has the prestigious status and high esteem of a profession (Freidson, 1988).

In the past there had been many different types of healers. In the Middle Ages the rise of European universities meant that healing gradually moved into the realm of a learned profession. At this time there was much competition for authority over medicine (Margotta, 1996). Initially practitioners organised themselves into professional bodies which then joined with universities. Then it was argued that only university graduates could practice medicine. Consequently medicine increasingly became text based (Porter, 1996) and the free market of healing was increasingly restricted.

The dominance of medical practice had to be fought for (Seale, 2001). As the medical faculties and professional organisations gained power, unlicensed practitioners were prosecuted (Magner, 1992). The development of scientific knowledge, from late nineteenth century, contributed to the process of medicine monopolisation. Biomedicine began to be considered superior to other forms of healing. In 1880s scientific knowledge was used in public health causes (sanitation) increasing doctors' authority and links with the state. Friedson (1988) argues that the foundation of control of the medical profession is political in nature.

Monopolisation and resistance to other groups was first demonstrated by the early exclusion of women from formal education that resulted in their exclusion from medical practice. This exclusion of women continued with midwives' role being largely over taken by the medicalisation of birth (Magner, 1992) until more recent times. This resistance to others extends to similar occupations and is demonstrated in the history of the American Medical Society (AMS) which was founded in 1844. At the time homeopathy was the

predominate system of medicine in America. However, in 1855 AMS established a code of ethics that asserted that members would lose their membership if they consulted with a homeopath or other 'non-regular' practitioner. Indeed, one respected member of the AMS asserted 'we fought him (homeopathy practitioners) because he came into the community and got the business' (Steriti 2004).

In 1858 the Medical Reform Act set up the General Medical Council, a single register for 'qualified medical practitioners' stipulating that only university and established corporations could grant medical licenses (UK). This established the framework for the growth of primary care in America for the next century. It wasn't until the 1880's that state licensing was instigated, prior to this anyone could set up as a doctor in USA (Margotta, 1996). Finally in 1910 the Flexner Report resulted in the rise of standards for medical schools, this led to the closure of many schools including naturopathy and homeopathy such that by 1918 only one homeopathy school had survived (Steriti, 2004). AMS had successfully undermined a major competitor in health care, homeopathy.

More recently the American Medical Association AMA (US) attempted to eliminate chiropractic practice. Attempts to eliminate the profession of chiropractic involved legal battles with the first trial favouring medical practice. However, a retrial beginning in 1987 resulted in a reversal of the original judgement in 1990 (Villanueva-Russell, 2005). The judgement included stipulation that AMA was forbidden to make any further negative statements against the profession of chiropractic. AMA was forced to accept chiropractic practice within health care.

On the other hand the British medical profession tends to marginalise alternative forms of healing, tolerating them so long as they do not illegitimately claim to possess medical or allied health professional qualifications (Saks, 1994). Thus maintaining a relatively open market however alternative healing practices do have a disadvantaged competitive position. Australia currently also has a relatively open market but alternative health practices are competitively disadvantaged as they are not subsidised by the state as biomedical practice is.

Resistance is not the only strategy used by the medical profession to maintain their monopoly. Integration or absorption of others fields of healing into medical practice

(Friedson, 1988) is also carried out when there is evidence of the competitive practice being effective. This can be seen in the healing occupations of Traditional Chinese Medicine, Acupuncture and Meditation; all have limited acceptance and integration into the mainstream practice due to the provision of evidence of their effectiveness. This process is a controversial one as the benefits of recognition and acceptance verse the loss of core principles of practice are debated.

The issue of evidence of effectiveness is increasingly a point of discussion as it is acknowledged that medical practice today is only loosely based on evidence and that

medicine often questions new ways of intervention that are outside of present medical model, more strongly than themselves and perhaps they ought to consider the possibility that they need to attend to experience and reason, as despite not being able to understand the mechanisms of how they work, within biomedical paradigm, there is mounting evidence for the efficacy for some alternative practices. (RACGP, 2000a)

RACGP (2000a) suggests that ‘...orthodox medicine needs to be more careful of preserving its scientific objectivity or risk of condemning modern day Galileos...’ Thus the idea of rejecting practices that do not have evidence that fits the current medical model in order to preserve the objective base is fundamentally shaky.

There is indication that doctors are increasingly open to alternatives, such that the development of practitioner friendly information service on complementary therapies; the promotion of Government health web links for consumers to access quality information on complementary therapies; the establishment of professional standards and monitoring processes to assure public of quality CAM practitioners are recommended (RACGP, 2000b). Demonstrating a strategy by which some medical practitioners are responding to public demand for alternative therapies in their health care.

The threat to professional power from such alternative practitioners remains a concern for some in the modern medical establishment. At the same time, many orthodox medical

practitioners are concerned to use therapies that are effective, whatever their knowledge-base maybe. (Seale, 2001)

Nursing

Nursing practice provides an example of restriction in the professionalisation process due to the service ideal being shared with an already established profession. Nurses have long attempted to distinguish themselves from medical practice by establishing their own area of autonomous competence (Witz, 1994). They have successfully obtained occupational closure using credentials, registration of practitioners, linking education with occupational practice and occupation theoretical knowledge and its practical application (Witz, 1994). Nursing practice is the traditional semi-profession to medicine and despite concerted efforts to professionalise with significant progress it is still considered a semi-profession by some.

As part of the process of professionalisation nursing has developed into a largely university based discipline with two forms of professional identity: a patient-oriented or carative one and an achievement-oriented or curative one (Ellis-Scheer, 2001). This distinction shows up the philosophical difference in practice that divides the practice's members. 'some nursing theorists maintain that 'caring' is still the core of being a nurse while others emphasise that nursing today is an 'evidence-based' profession...' (Ellis-Scheer, 2001). Witz (1994) suggests a combined path with the nursing process a problem solving, patient-centred, systematic and analytic approach where patients are seen as partners. Unfortunately the service ideal is not distinct enough from the medical profession and this restricts the potential for monopolisation. Despite this many nurses do consider the field a 'profession' questioning the idea of what a profession is.

Traditional Chinese Medicine

Traditional Chinese Medicine (TCM) is a good example of an alternative health modality that has managed to make significant progress in its professionalisation process. It is an indicator of what is required of a health care modality to professionalise in Australia. Remembering that the key concerns for the Australian government for statutory registration are risks to the public health and safety and whether regulation would effectively deal with these risks when no other option is available to do so (Carlton, 2003).

A review for TCM regulation commenced in 1995. It was undertaken by the Victorian Government of Human Services on behalf of all states and territories of Australia and was in response to the rapid growth of TCM practices, the demand for these practices and expressed concern regarding this trend, particularly related to increased consumer complaints (Carlton, 2000). The first stage of the review was a research project to investigate the risks and benefits of TCM and the nature of the TCM workforce, in order to consider the need if any for the registration of TCM practitioners and the regulation of Chinese herbs.

The result of the first phase investigation was the recommendation for registration of the occupation to proceed as a matter of urgency (Carlton, 2003). This was because adequate evidence was found of risk, both inherent in the practice itself and associated with poor practitioner training (Carlton, 1998). TCM practice was found to need a high standard of training; a need for the public and other health care professionals to be able to identify practitioners who are well qualified; and a means for consumers to access an effective mechanism for dealing with complaints (Carlton, 2000). As a consequence of these findings the second stage of the feasibility of registration was instigated.

During the second stage of the review four main reasons for the undermining of effective self-regulation of TCM were found. They were: fragmentation of the profession and lack of agreement on standards; deregulation of education provision; difficulties with creating sufficient incentives for voluntary certification; and lack of access to restricted herbs scheduled under the Victorian *Drugs Poisons and Controlled substances Act*. It was considered that given the risks, self-regulation was unsuitable and the enforcement of standards of training and practice was appropriate (Carlton, 2000). Legislation occurred in the form of the *Chinese Medicine Registration Act 2000* by the Victorian Government and as a result the Chinese Medicine Board of Victoria was established. Other states and territories of Australia are yet to act on the recommendations.

Importantly the TCM review process was an opportunity to point out that self-regulation is the option of choice when breaching standards of practice is not catastrophic (Carlton, 2003). For example the Australian Massage industry have made submissions for registration of the industry due to a need for the public to have access to reliable information on who is a qualified practitioner and who is not and because of the problems

reputable practitioners have related to the interface between the massage industry and illegal sexual service (Carlton, 2003). These issues do not provide indication for the need for legislative action. However the occupations significant steps towards self-regulation have been noted, encouraged and ways for strengthening their self-regulation have been considered (Carlton, 2003) in order to address the industry's concerns.

Psychotherapy and counselling

The occupations of counselling and psychotherapy are active in the process of professionalisation, however the appropriateness of doing so is debated. According to Howard (1998) counselling has taken on the trappings of a profession with registration, accreditation, supervision and a code of ethics, but he questions the reality of it having achieved becoming a profession. Postle (2000) notes that

client-protection and practitioner-competence issues are perhaps the two most powerful reasons cited in support of current professionalising developments; and if it can be shown that the respective rationales underpinning these two positions are based on inadequate and erroneous reasoning, then the whole raison d'être for professionalisation is at the very least thrown into severe doubt.

Further arguments against the professionalisation process are based on two primary grounds: first that the industry fails to meet the criteria of a profession, due to a lack of evidence of risk, effective knowledge base or training that ensures competent practitioners and; secondly that professionalisation philosophically is inappropriate for the industry.

Mowbray (1995), House (1995) and Howard (1998) argue that there is no evidence of risk to clients significant enough to warrant legislative action. Indeed they believe that legislative action would increase potential harm to clients. Mowbray (1995) and House (1995) argue accreditation fosters the myth that the public can be protected from the difficulties of making the choice of appropriate practitioner for themselves and increases dependency on others to make such a choice for them. Howard (1998) echoes this argument asserting that due to the tendency for individuals to overly trust the assumed authority of another, believing them to know what they are doing such that they tend to

become more dependent, more trusting and less questioning of the therapist, this dependency results in the disempowerment, disabling and even confusion of the client.

Significantly Mowbray (1995) argues that registration has not been shown to be an effective means of protecting the public. While Postle (2000) points out that it is a false view that stricter controls are required to protect the public from unscrupulous practitioners. It is argued there are better ways to protect the public especially when there is no evidence of risk in the practice itself. Offering an alternative to registration, Mowbray (1995) suggests other ways of reducing charlatan practice including: education of the public particularly on criteria for selection of practitioner; promotion of informed consumer choice; and information on potential pitfalls and transference.

Addressing the issue of a professional knowledge base Howard (1998) argues that counselling fails to fulfil basic requirements of being a profession. He states it is due to a lack of consensus of an essential knowledge base and evidence for effectiveness of the practice. Whilst traditionally professions have *professed* to have knowledge and skills that haven't actually been proven, it is recommended that counselling takes a path of higher integrity, by establishing an evidence-based knowledge base such that 'genuinely effective services are developed and available' (Howard, 1998).

As another aspect of the training debate Howard (1998) asks if professional counsellors get better results than amateurs. While House (1995) and Mowbray (1995, 1996) argue there is no evidence that training provides better practitioners. Howard (1998) points out that currently in counsellor training, almost anything goes and practitioners are more like 'gurus' than 'critical and questioning students' and that at present proposed practice outcomes, tend to be vague and lacking any tangible substance to them. This vagueness undermines the potential to observe effectiveness. Howard (1998) goes on to argue that a set number of hours of training is not adequate as for a profession the training contents requires a consensus of an essential knowledge base that is relevant and desirable, and a core curriculum that provides a broad overview of the profession rather than a certain number of hours of training.

According to Postle (2000) it is not possible to generate or guarantee competent practice in the field by training and formal top-down accreditation and registration procedures. He

argues for a different training structure more suited to the practice outcomes. As the occupation is about empowering clients the hierarchical framework of current training organisations undermines the growth of trainees regarding power issues. In agreement Mowbray (1995) states ‘where there is a genuine need for structures, we should develop structures that foster our values rather than betray them’. The Independent Practitioners Network attempts to devise a viable process of self and peer accreditation and validation that both recognises and transcends the often infantilising dynamics around power (House, 1995) associated to hierarchical frameworks including professionalisation.

The idea of an appropriate training structure points out the philosophical principle behind professionalisation is of authority, where one defers ones power to a professional who is said to be better able to know what is appropriate, transferring the responsibility for appropriate action from oneself to an expert. This philosophy is also the basis of the hierarchical educational system. Alternatively the idea behind personal growth work is to increase mature adult functioning, personal responsibility, ones trust in oneself to know what is most appropriate for oneself and make ones decisions on that and gathered information, in essence to support autonomy. This approach is not the sort of activity in which one defers to an ‘expert’, rather functioning adults are encouraged to make choices for themselves (Mowbray, 1995).

Still related to the philosophical approach it is noted that as part of the professionalisation process there is a strong tendency to move, in counselling, towards the medical model and a cost effectiveness approach with a trend to audit and evaluate. Mowbray (1995) suggests reflecting on the implicit assumptions underlying the empirical methodologies that are actively and increasingly being taught in counselling. He argues

it would surely be a tragedy if our profession, based as it is on person-centred, holistic values, were to go down the same road of sterile and soul-less empiricism.

with

the aims of prediction and control and a style of planning and decision-making in which emotional and aesthetic considerations are subservient to the rational and pragmatic. (Mowbray, 1995)

For counselling and psychotherapy are an experiential task of working through and integrating repressed and unintegrated material while the bureaucratic process is one of quietly smothering the growth of others (Mowbray 1995).

The deficiency and standardising approaches of medical model with disorders that need repair are in conflict with human potential work which has different goals (Mowbray, 1995). House (1996a, 1996b) points out that removing a symptom doesn't relieve the patient or client of the bulk of their emotional problems and that the medical model approach doesn't hold for psychological, emotional difficulties. He suggests that it is a comparative comfort which the inadequate paradigm (medical), with its mechanistic, rational based, control oriented mentalities and avoidance of the subjective meaning that is an issue. House (1996b) states

the idea of the risk of betraying the foundational principles of the practice and world view, of humanistic and holistic principles, to fit in with the market-place more mechanistic therapeutic approach whose values and views of the person are very different and largely incompatible.

Not only are the goals and principles different, but also the target clientele. Mowbray, (1996) points to a need to distinguish between human potential work and remedial treatment work. Practices based on empowerment and growth principles are utilised by people that are as well as the next person and it is questioned that they would want to be defined as unwell. In counselling and psychotherapy the focus is on self-actualisation, self-knowledge with the goal of fulfilling more of who one is and its goal is a process not an end point. The client is supported in exploring ones experience and meaning such that symptoms are owned and seen as a form of communication.

Humanistic principles include the idea of life as a process where change is inevitable, with an appreciation of spiritual and intuitive (AHP, 2003), where growth, potential and

increased personal power or autonomy are the intended outcomes. The service is intended for the average adult who desires growth and increased self-actualisation, distinct from physical illness of the medical approach. These two fields are addressing different aspects of life and require different terminology and ought not be confused, it is argued that they are incompatible and professionalisation is not suitable for practices that are founded on humanistic holistic principles. Postle (2000) notes ‘the full import of views which are so counter-culturally challenging to established beliefs about accreditation and professionalisation.’

House (1995) sees the professionalisation process as a ‘largely unquestioned and intemperate stampede into registration-and accreditation-mindedness’ ‘being swept along the tide of hierarchical professionalisation in a largely uncritical and unproblematised way.’ Mowbray (1995) notes that the drive for legislation is practitioner and particularly training organisations based, it is not a government initiation rather it is based on a fear of not being able to practice, of being registered out of work. The professionalisation of the psychotherapeutic and counselling fields is driven by practitioner needs and power dynamics, rather than client autonomy or consideration of the philosophical underpinning of the industry.

House (1995) also suggests that the professionalisation of psychotherapy is driven by fear and a ‘kind of lemming-mindedness’ and argues that at the heart of the debate of professionalisation is the dynamics of authority and power and its shadow powerlessness and victim hood, believing that

arguments against professionalising a field centred on human development and healing to be so self-evident and overwhelming that no-one with any degree of integrity or understanding of the nature of personal growth could countenance even for a moment the kinds of extraordinary changes that have been occurring.
(House, 1995)

Lamont (1995) deemphasises Mowbray’s focus of motivation related to earnings, preferring to focus on the idea that

practitioners do feel vulnerable and one way to protect that vulnerability is to earn credentials which confirm our proficiency, and then to buy an insurance policy, just to be on the safe side... If we are choosing a path of registration as an answer to our uncertainties, then we should be stopping and examining those uncertainties, not pushing ourselves toward premature resolution.(Lamont, 1995)

It is argued that professionalisation, in this case, is driven by a sense of vulnerability and based on practitioners' fear of not being able to practice.

Mediation

In the UK Grossman (2003) pointed out that the professionalisation of the mediation occupation is currently problematic because it: relies more on learning capabilities across disciplines and a high level of interpersonal skills than it does on the possession of a highly defined body of knowledge as mediation is a derived discipline, that has a cross-disciplinary area of knowledge; and at this stage of development just what it is that is to be regulated is unknown as the field is not clearly defined. Thus emphasising the importance of clearly defining, distinguishing and developing the occupation from others professions for the purpose of professionalisation. It is also noted that an effective mediator is not a guaranteed result of training and that commercial mediation services may have little need of regulation as an increasingly sophisticated market is able to determine for themselves the quality of the mediators.

Coaching

Coaching is an example of an occupation using awareness and a systematic process for their professionalisation. In Australia coaching practice has grown, with interest demonstrated by psychologists, business management and freelance or general practitioners. With courses provided by universities and private training groups alike. Consequently it is an occupation with a diversity of education standards and practices. Currently there are attempts, in Australia, to unify and professionalise the industry. To this end a conference was held in November 2003 where interested parties representing a range of approaches to coaching collected to discuss issues of professionalisation focusing on standardisation of training and practice.

At the conference Gale (2003) presented that there were three key challenges for the professionalisation of coaching: defining standards of service and performance that do not inhibit the individual; the development of a more coherent and well understood perception of the nature of the benefit of the industry and; to establish a robust and durable coaching business. He argued that professionalisation of the industry was appropriate because as there are no substantive minimal standards or qualifications recognised in Australia, there is a risk of diminishing the perception of value of coaching and possible litigation. Further that it was important to be proactive in taking the industry forward. Failure to be proactive, he noted, meant risking outsiders imposing their will upon the industry and this would result in the industry losing its ability to be self-determining. If this was to happen it would not necessarily be the best outcome for the industry. Newman (2003) then argued that it was important to maintain awareness of what distinguishes coaching from other similar occupations and intellectual rigour around standards, indicating an understanding of the need to clearly distinguish the occupation of other related fields.

Summary

Professionalisation is a process that many occupations undertake despite the challenges they face. Traditionally the goal of the professionalisation process is to become a profession and obtain the associated benefits. Meeting the criteria of a profession requires the industry to develop a clear unique and valuable service for the public, as well as developing and maintaining control over an appropriate knowledge base. Further it is important to demonstrate a risk associated to the use of the knowledge in providing the defined service to ensure a need to control the field. Many occupations that begin the professionalisation process simply do not succeed in achieving the goal of becoming a profession. However professionalisation may be undertaken primarily to set and or improve industry standards, focusing on improving the quality of service to the clients rather than on becoming a profession.

Before an occupation considers professionalisation it is worth considering the expressed concern over the 'uncritical rush' into the professionalisation of some fields (House, 1996a; Grossman, 2003). Professionalisation may not be appropriate for an occupation due to inadequacy in any of the three core criteria of a profession or on philosophical grounds. It

is also important to consider if there are the resources for the process and any potential resistance to the occupations development from an established profession.

This chapter completes the background information for the study. Now attention can turn to the study it self, the professionalisation of aromatherapy. As there are different reasons for professionalisation and a number of issues to consider in professionalisation process, it is important to ask what aromatherapist want for their occupation and if they can see obstacles for the professionalisation of aromatherapy. It would also be of value to get some insight into whether aromatherapy practitioners themselves believe aromatherapy to be a profession and if so what they understand a profession to be?

Further by gathering insights from related professions and or occupations it is possible to consider the professionalisation process within the larger context by including other actors in the professionalisation process. This information will enable a discussion of the potential professionalisation of aromatherapy practice in Australian health care, building on the industry's understanding a profession and the historical development of the industry. In Part Two of this thesis these issues will be examined.

Part Two

The Study

*The terms method and methodology are frequently used interchangeably,
(and) they should be thought of as
distinctly different concepts*
Fontana, 2004

Chapter 6

Methodology

Methodology can be defined as the way in which theory and epistemology are utilized in a specific study. It is a more philosophically value laden concept than that of method and reflects the overall conceptual approach of the inquiry. It is the way in which the phenomena are approached and interpreted and not the method of data collection that defines critical studies, since they operate at the level of methodology and require contextual decisions instead of technical ones.

Fontana, 2004

Scientific research aims to expand our understanding of reality by the systematic and rigorous production of knowledge guided by a theoretical framework known as the methodology. The methodology describes the understanding of reality, the beliefs of how we can know that reality and the manner in which we can gain knowledge of it. There are a number of methodologies used in scientific research. The most important criteria for the choice of methodology for any particular research project is that it 'fits' the study. This chapter will outline the study the aims and propositions. This will be followed by an outline of major methodological paradigms providing a brief description of choices including ontology and epistemology of scientific inquiry. Finally this chapter will outline the methodology used, the reason why it was selected and the researcher's stance.

I The Study

This study is to investigate and consider the professionalisation of CAM related to the previously described social crisis (Chapter One) in which the dominant health care system is being forced to adjust due to the increase demand for CAM services. More specifically the study is looking at the occupation of aromatherapy practice and the options it has for its professionalisation as a case study in this time of change. The intended purpose of the study is to provide the potential to empower CAM occupations especially aromatherapy practice in the current health care setting.

Study aims

The intention of this study is to empower CAM occupations, especially aromatherapy practice's developments in the current health care setting. Thus it aims to investigate the process of professionalisation related specifically to CAM in the Australia health care system. The intention is to clarify relevant pathways for the professionalisation process of CAM occupations and as a consequence provide an opportunity for individual occupations to partake in an informed and proactive role in the occupation's development.

To enable this process the current situation of CAM occupations needs to be considered around such issues as how members of an occupation see the occupation and what they want for their occupation. This study focuses on aromatherapy as a case study and has established in previous chapters that aromatherapy practice is presented as a profession

despite not meeting the criteria for one. As a consequence the study aims to gain insight into whether aromatherapy practitioners and related actors in the professionalisation process do perceive aromatherapy to be a profession, what they understand a profession to be and what aromatherapy practice would need to do to become a profession. The study also aims to gain insight into what aromatherapy practice is, what aromatherapists want for their occupation, the perceived value of the practice and any perceived obstacles for the development of the practice. The collection of these data allowed comparison with literature data, the development of a plausible explanation for any belief that aromatherapy is a profession and to improve relevance to those involved. Finally, the study also aims to explore the likely pathway for the development of aromatherapy practice from the data that have emerged in this study. The aims of the study are listed in Table IV.

Study propositions

As aromatherapy journals refer to the practice of aromatherapy as a profession it is likely that many aromatherapists see aromatherapy as a profession, thus the first proposition of this study is that aromatherapists view aromatherapy as a profession. At the same time it is considered less likely for other health care workers to see aromatherapy as a profession, this being the second proposition. The third proposition is that aromatherapists want recognition as a legitimate health care practice. These propositions are listed in Table V.

II On Reality and Knowledge

Ontological views, views of what exists, can be broadly separated into two paradigms. The first is that of the world of a purely material reality. In this paradigm reality is fixed, objective, observable and measurable; it operates in terms of cause and effect and thus is predictable and controllable. In this paradigm reality is linear in nature. The second paradigm views reality as a world of the material and something else generally referred to as spirit. In this paradigm it is the human spirit that allows us to think, feel, communicate, experience, to have dreams and desires of our own. It also enables us to choose our response to a stimulus, or initiate stimuli and create. This ability to choose ensures unpredictableness not recognised in the first view of reality and adds an extra dimension of substance to reality that is not directly observable, nor measurable, yet exists as an important quality and component of reality. In this paradigm reality is holistic in

Table IV
Study aims

1) Consider the professionalisation process of CAM in Australia health care.
2) Consider the impact of other healthcare professions and the Australian government on the potential pathways.
3) Consider potential pathways for the development/professionalisation of CAM in the Australian health care market.
4) Empower CAM occupations
5) Gain insight into whether participating aromatherapist and other health care workers perceive aromatherapy to be a profession.
6) If so what they understand a profession to be and consider plausible reason for the belief.
7) Determine/outline what it is the practice of aromatherapy would need to do to fulfil the criteria of a profession.
8) Gain insight into what aromatherapy practice is according to aromatherapists and other health care workers.
9) Gain insight into whether aromatherapists' want recognition for the practice of aromatherapy as a health care modality.
10) Gain insight into how aromatherapists and other health care workers perceive aromatherapy might fit in to the Australian health care system.
11) Gain insight as to what they want for the future of aromatherapy practice.
12) Gain insight to the perceived obstacles to the occupations development in health care.
13) Explore likely path for the development of aromatherapy practice in health care.

Table V
Study Propositions:

1) Aromatherapists believe their occupation to be a profession.
2) Other health care practitioners do not see aromatherapy as a profession.
3) Aromatherapists want legitimate recognition for their practice.

nature with growth and change part of reality.

These two views are reflected in the concepts and practices of natural science and social science. Natural science is that of the physical sciences, the study of the physical world (Collins, 1990). On the other hand social science is the study of society and relationships of individual members in society, including economics, history, political science, psychology and anthropology (Collins, 1990). It asserts that social reality exists in meaningful social interactions with others and that reality is not fixed, it changes and develops according to peoples' experience and social context⁸.

Paradigm of scientific inquiry

Epistemology, what we can know of reality, also has different approaches or paradigms. One paradigm, known as positivism, is based on the belief that reality is fixed and that our knowledge base can be an accurate representation of reality. This approach became known as naïve positivism and was modified to form post-positivism or interpretative, a second paradigm. This paradigm developed with our knowledge base and the recognition and acceptance that we as observers are unable to see the totality of what is before us. This is because we have selective perceptions and interpret what we observe, via our beliefs and current knowledge. As a consequence it is accepted that we can only obtain a reasonably close representations of reality (Guba, 1990). Both positivism (naïve realism) and post positivism (critical realism) assume there is a fixed reality.

More recently a view, known as constructivism, developed which is founded on the idea that not only do we select and interpret what we see we also influence what we see and what happens thereafter. This view holds that we are constantly gathering and adjusting or strengthening our knowledge base as a representation of reality and thus effectively we are constructing our reality. The understanding of what we can know of our reality changes from the concept of a fixed reality, to a view that we construct our reality. Any reality that we construct is not fixed and varies with our understanding and thoughts of what reality is. In this paradigm reality varies over time and between contexts, just as the paradigms of epistemology, as described here have (Denzin & Lincoln, 2000).

⁸ Not all theorists separate the paradigms this way for some do apply the view of fixed causal reality to social reality.

Guba (1990) describe three broad paradigms, used to guide scientific inquiry: positivism; post-positivism and; critical theory (constructivism), that correspond to the previously mention epistemology paradigms. More recently, Lincoln and Guba (2000) divide the paradigm of scientific inquiry further providing five groups: positivism based on naïve realism; post positivism based on critical realism or interpretation; critical theory based on historical realism, where virtual reality is shaped over time; constructivism based on relativism with local and specific realities; and participatory based on participatory reality, where participants co-create reality. These paradigms are used to guide scientific inquiry, with more specific theoretical frameworks within the paradigms, for example symbolic interactionism, grounded theory and critical theory. Lincoln and Guba (2000) noted that it is possible to have some blending between the paradigms, for inquiry purposes, except if the philosophical axioms are contradictory.

The paradigms can be grouped into the modern and post-modern perspectives. According to MacDonald and Schreiber (2001) the modern perspective is of an objective reality as seen in positivism and natural science. While the post-modern acknowledges the role of the mind, encompassing the interpretative, constructivism, critical and participatory views. It is described as being anti-foundational, with no firm truth; with profound distrust as all is relative; it challenges the tendency to over look difference and go for the ‘norm’ which leads to marginalisation of those without power; it acknowledges cyclic changes; supports authenticity, multiple realities; considers the tension between humanity and technology; and accepts that ‘words’ are a form of authority and power. Taylor (2002) points out the negative extreme of post-modernism views nothing as knowable, suggesting there is no point in research, she also notes there is an affirmative post-modernism with a realistic balance.

The post-modern perspective features an increasing awareness of difference between concepts and models used by professionals and other groups in society, as well as the many factors that influence the outcomes of interventions and thus cannot be ignored despite being difficult to measure. Such factors include social, cultural, historical, socio-economic and political factors. The emphasis is on collecting data from the perspective of researchers and researched, with rapid appraisal procedures to help identify local needs and priorities, a tendency to place issues in the context of lives and give direction to program development and service provision (Koning & Martin, 1996). Whilst the modern approach assumes there

is a fixed reality, post-modern approaches questions assumptions and advocates multiple realities.

Knowledge and its scientific development

Scientific knowledge is not the only form of knowledge, according to De Poy and Gitlin (1994) there are eight ways of knowing: authority, heresy, trial and error, belief, spiritual understanding, intuition, historical and scientific. Knowledge can be built on any of these bases however as we have selective perceptions and interpret what we observe, our perceptions tend to distort reality. Scientific knowledge is produced by scientific research that is designed to systematically gather information and to provide a more accurate knowledge base. Scientific knowledge is socially accepted as the most accurate form of knowledge. Habermas (Emden, 1991) describes three types of scientific knowledge, whilst, Fay (1987) describes two distinct forms.

Habermas' (Emden, 1991) three forms of knowledge: empirical, interpretative and emancipatory, are associated to the three epistemology paradigms previously mentioned. Empirical knowledge is positivist in nature, it is technical knowledge that is able to predict and control. The interpretative approach is post-positivist in nature providing practical subjective knowledge that enables mutual understanding and has a regulatory ideal. The regulatory ideal is believed to provide a reasonably close resemblance to reality. Again it aims for prediction and control, whilst exposing the myth of objectivity. These two approaches correspond with Fay's instrumental conception of theory.

The instrumental approach advocates non-teleological, causal and nomological explanations, which support the capacity to predict rationally likely outcomes ideal for making interventions (Fay, 1987). As Fay points out

knowing the natural causes and effects of various events, agents will have a basis on which they can successfully intervene in the flow of events to bring about efficiently the results they desire.

(Fay, 1987: 86-7)

These approaches utilises experimental procedures to test hypotheses and the development of secular theories as emphasised in modern science.

Alternatively Habermas' emancipatory view of knowledge has a constructionist approach (Emden, 1991). It supports the critical assessment of knowledge, intends to deal with false consciousness and transformation to secure freedom from constraints and distorted communication. The idea that knowledge must make a contribution and that the true value of knowledge is in its use for social wellbeing and emancipatory purpose is a key factor. Similarly Fay's (1987) second form, the educative conception of knowledge focuses on social scientific knowledge and has the purpose of engendering self-knowledge to liberate people from oppression in their social arrangements. It assists people to see how they are systematically ignorant of their needs, their relationships and activities, so that they can see a new outcome, freeing them from oppressive and frustrating conditions.

Foucault (Danaher, et al., 2000) argues that scientific knowledge is no more accurate than any other form of knowledge. He argues that knowledge and truth is tied up with power and public truth, as the dominant ideology has the power to decide what is and is not valid knowledge. He argues that science, as part of its power, is used to regulate and normalise individuals. Similarly Habermas argues that science in its positivist form has become a form of ideological domination where critical reflection and protests are eliminated by the idea that experts know best. Further, it is argued that political decisions are made to promote the interests of the elite obscured by the ideological appeals to technical expertise (Adams & Sydie, 2002). Habermas does see science as having a place of value, but asserts that its domination is not inevitable. Still empirical, instrumental knowledge is currently the dominant form of scientific knowledge.

Quantitative and qualitative research

Quantitative and qualitative research designs are two approaches in scientific research. Quantitative research is based on the positivist paradigm that assumes reality is stable (Morse & Field, 1996) and that truth can transcend personal bias to provide an objective worldview and that research findings relate to researchers interpretation of data.

Traditionally quantitative research claims to be value free and is said to be objective, with the researcher a separate observing third party who is identifying and explaining, but not involved in the phenomenon itself. The empirico-analytical methods assume knowledge is only true and trustworthy if found 'objectively' (Roberts & Taylor, 1998). Quantitative research is research that focuses on measurement and systematic testing of deductive

theory (Morse & Field, 1996). Reliability and validity of the measuring instruments are essential, as is rigor and reproducibility.

Quantitative research uses numerical values, seeks causes and facts, looking for relationships between variables to explain causality so that accurate predictions can be made (Morse & Field, 1996; Denzin & Lincoln, 2000). Quantitative research addresses what, when and how questions. It uses data that is collected by the senses and can be used to measure at all four levels of theory: descriptive, co-relational, explanatory and predictive (Roberts & Taylor, 2002).

Alternatively qualitative research aims to illuminate peoples' interpretation of facts focusing on motivation, reason and understanding (Porter, 1996b). Qualitative data allows the world to be seen through the eyes of the participants (Bogdan & Taylor, 1975). It focuses on human consciousness, subjectivity, values and experiences and the changing nature of knowledge (Roberts & Taylor, 2002). Qualitative research is designed to answer why questions and is suitable for providing descriptive data and theory development research. Wainwright (1997) states that

Generally, qualitative research can be characterised as the attempt to obtain an in-depth understanding of the meanings and 'definitions of the situation' presented by informants, rather than the production of a quantitative 'measurement' of their characteristics or behaviour. (Wainwright, 1997; 2)

Qualitative research is usually conducted in natural setting so that context can be taken into account with no experimental controls placed on the phenomenon being studied (Morse & Field, 1996). Qualitative researchers stress the qualities of entities, on processes and meanings, the socially constructed nature of reality, the relationship between the researcher and what is being studied and the situational constraints that influence the enquiry. Denzin and Lincoln (2000) state that qualitative research has a long history, it is multi-paradigmatic and is many things.

By outlining the qualities of the two different approaches a dichotomy between the two approaches is implied. However, Porter (1996b) argues that neither fit the described criteria

perfectly and thus a false dichotomy can be perceived. Whilst many researchers advocate the complementary value of quantitative and qualitative research the debate around them continues with critiques of each approach. Qualitative researchers' acknowledgement of the value-laden nature of research is seen as an attack on the assumed objective nature of quantitative research. On the other hand qualitative researchers see positivist quantitative researchers as attempting to legislate one version of truth over another (Denzin & Lincoln, 2000). According to Yacopetti (2000) a major criticism of quantitative research is that it is reductionist in nature and that it fails to produce socially relevant data and ignores power relations. Qualitative research, on the other hand, is criticised for not producing data that is credibly transferable or able to be generalised.

Wainwright (1997) believes that qualitative research has developed a tendency to adopt an uncritical attitude to the beliefs and behaviour of informants without considering their emancipatory power. This lack of willingness to place judgment leaves the researcher in a position of impartial reporter, he states

the reluctance to address the processes by which different forms of consciousness are socially and historically constructed, coupled with the absence of any evaluation of the epistemological status and emancipatory potential of a set of beliefs, amounts to little more than a passive legitimization of dominant ideology. (Wainwright, 1997; 2)

Theory and practice

The development of applied scientific knowledge has the intention of supporting practice. Unfortunately at times developed theory is not practical in nature and a theory practice gap referred to as praxis is noted. The importance of theory and practice being in dialectical relationship is recognised as an important consideration in research, to ensure the relevance of data to practice. Similarly the value of scientific knowledge for health care was recognised with the realisation that practices in health care based on traditional and clinical knowledge are not always the most effective practice.

From this awareness the demand for 'evidence based' practice was established. This is a relatively new development in biomedicine and health care practices. The need for

scientific research that relates to practice and supports practice is considered a basic requirement for health care today. Evidence-based medicine is defined as the process of systematically finding, appraising and using contemporary research as the bases for clinical decisions. It reduces the value of clinical experience whilst increasing reliance on literature (Kyriacou, 2004) and as previously noted⁹ may adversely affect patient care by devaluing non-evidentiary aspects (Dobbie et al. in Grant, 2003b) without any evidence that EBM improves patient treatments and outcomes.

III The Chosen Methodology

In order to find the methodology that best fits this study it is necessary to keep in mind the intention of the study, the importance of keeping the study relevant to practical reality and be aware of the different paradigms and modes of enquiry available, in this way it is possible to consider the methodology that is most likely to provide the knowledge that the study intends to provide.

The intention of this study is to provide knowledge that empowers CAM occupations to be free from oppression and develop as the occupation desires. To do this ‘aromatherapy practice’ will be the focus of the study and presented as a case study. The three institutions that play a major role in the study, health care, profession and aromatherapy, are all social constructed and context related, this is an important consideration when choosing the methodology. To ensure relevance of the knowledge developed it is important to consult with members of the aromatherapy occupation and because of the role they can play in an occupation’s professionalisation process, related occupations. The fundamental underpinnings that the chosen methodology must take into consideration are the intention to produce emancipatory knowledge; the social constructed nature of phenomena; and the importance of current relevant information.

Qualitative methodology

Qualitative methodology is essential for this study as the study aims to see the world through the eyes of the participants gathering insights into individuals and groups perspectives of what aromatherapy is seen to be along with its desired future. The

⁹ See page 42

requirement is reinforced as aromatherapy practice has a very broad definition with multiple socially constructed meanings and as such it is not suitable for concise definition and measurement. Quantitative research is not as suitable for this study, as the study is not looking at the measurement and systematic testing of deductive theory of relationships between variables seeking to explain causality so that accurate predictions can be made.

Symbolic interaction, socially constructed

The phenomena being studied, profession, health care and aromatherapy are socially constructed institutions and practices created via interactions between individuals and groups. As a consequence what the terms refer to can vary over time and between members of society. The socially constructed and changeable meaning of the phenomena under study ensures the epistemology for this study is of the post-modern constructive paradigm and is in the realm of social reality, it is of the world of human spirit and not of a fixed physical reality.

The appropriateness of the post-modern approach for this study is reinforced as the study aims to challenge assumptions, highlight multiple realities and challenge the idea of a fixed reality by looking for options for a changed future. Whilst featuring an increasing awareness of the many factors that influence outcomes of interventions that cannot be ignored. Such factors include social, cultural, historical, socio-economic and political factors. A fundamental belief underpinning this study is that discourse and social interaction construct meaning and reality.

According to Karp and Yeols (1993) there is no inherent meaning, meaning is formed from the response individuals make, where social reality is constructed and meaning is derived in terms of use. The symbolic interaction perspective centres attention on how individuals interpret and give meanings to the daily interaction that make up their social worlds.

Herbert Blumer (Karp & Yeols, 1993) states the central premises of symbolic interaction are: humans act toward things or situations on the basis of the meaning that thing or situation has for them; these meanings are derived from social interactions individuals have with each other and; these meanings are handled or modified through the interpretive process used by individuals in dealing with the things or situations they encounter.

Symbolic interaction informed the study because of the socially constructed nature of

‘aromatherapy’, ‘health care’, and ‘profession’ and its emphasis on meaning via interaction.

Symbolic interaction illuminates the relationship between individuals and society where the meaning of an object is created via both internal dialogue and discourse with others (Porter, 1996b). However this study is not simply about the meaning of the phenomena, it is more specifically of a social crisis and the potential for transformative emancipation. Symbolic interaction fails to fully fulfil the requirements of this aspect of the study.

Critical theory

The study intends to deal with false consciousness and transformation to secure freedom from constraints by providing emancipatory knowledge. It aims to inform and ideally empower CAM practices, in particular aromatherapy, in order to support the occupation’s self-determination. Critical theory is the methodology that is designed for this type of knowledge development. Critical theory is the most suitable methodology for this study because it attempts to reveal what is preventing individuals and groups from effectively making the decisions that critically affect their lives, remembering that no one is ever completely free of the socio-political context (Kincheloe & McLaren, 2000). Harper and Hartman (1997) state that critical social theory goes beyond the interpretative approach it emphasises the socially constructed nature of knowledge and ideological domination.

There are many visions of critical theory. Fontana (2004) argues that ‘methodology in critical science has not been clearly articulated.’ Core aspects of critical theory are that it utilises historical knowledge, reflexive reasoning and ironic awareness to support people to realise new potentials rather than utilise a set-piece research strategy using formalistic methodology (Luke, 1991). It has the goal of guiding human actions to realize emancipation whilst being aware of cultural and psychological constraints.

Critical social theory critiques existing conditions for the purpose of enhancing individual autonomy and responsibility. It has the intention of arriving at an emancipatory version of the truth, intending to provide the actual or potential power to transform the situation under study empowering people to overcome oppressive domination. Transformation is made possible by exposing oppressive beliefs that restrict people, these beliefs are referred to as false consciousness or distorted communication (Adams & Sydie, 2002) and by providing

alternative realities (Turner, 1998). Freedom comes from being aware of what is happening, then in finding the motivation and means to do something about it (Taylor, 2002).

In critical theory historical development is important for it is accepted that discourse adjusts and modifies meaning over time, rarely if ever does discourse instigate a whole new meaning, thus the 'present is made up of threads and ideas from the past' (Foucault, 1972). Historical development is a significant contributor to today's meaning and reality and by looking to the past for its progression one is able to project into the future. Cox (Fontana, 2004) states to be a critical theorist is to stand apart from the prevailing world order and ask how it came about. It involves a mode of thinking and acting, which focuses on deliberation and reflection and involves patterns of thought and action that challenge institutionalised power relations.

Its role is to achieve emancipation through radical reflection, where one attempts to examine roles and habits that are accepted without question in order to develop self knowledge and gain power over those forces that control one's life. These forces include both external forces and internal struggles (Yacopetti, 2000). Luke (1991) argues that critical theory must adopt the goal of guiding human action to realise greater emancipation and enlightenment in the lives of people, lessen the victimization imposed on them from within or forced upon them from without whilst acknowledging the cultural and psychological grounding of the people it addresses. Further, he argues, it must advance systematic radical critiques of society providing guidelines for resistance groups at margins of society. Remembering it is not enlightenment to simply impose another belief or attitude, to allow this a critical theory must be such that the group is free to reject it if they so desire (Fay, 1987).

Importantly critical researchers are not satisfied with simply increasing the knowledge base, they often regard their work as the first steps in social change, openly stating their assumptions and announce their partisanship in the struggle for a better world (Kincheloe & McLaren, 2000; Yacopetti, 2000). According to Fay (1987)

critical social science seeks to be practical in the sense of being a catalyst for fundamental social change. The process by which

this is effected consists of two elements: the education of the audience and their empowerment. (Fay, 1987; 85)

Critical theory methodology matches the intended purpose of the study well and thus was chosen for the study.

This study is based in Fay's (1987) basic scheme of critical theory. This approach requires a conflict in which group members are suffering and the conflict is at such a proportion that it threatens breakdown of society (yet not all happen to this degree). He argues that it is necessary to show suffering is the result of false consciousness, assume members wish for the suffering to stop and demonstrate that by gaining a new self understanding they can free themselves of the suffering. Whilst providing an alternative conception of self and motivation to change, critical theory aims to 'do justice to the chaotic and self-defeating character of the behaviour it wishes to understand and ultimately to alter' (Fay, 1987).

Criticisms of critical theory

Critical theory has been criticised as having a tendency toward elitism (Clark, 2003) in that the researcher assumes they know best. This is in agreement with Oliga (1996) view that Fay's sub theory 10 is at risk of instigating tyranny or quietism by promoting or providing an alternative oppression. To counter this risk, this study aims to promote the encouragement of empowerment by providing information and options rather than prescribe a particular path for transformation. Indeed this is in alignment with a humanistic critical social theory. The researcher is not promoted as an expert on what ought to be done, rather as having the expertise to analysis the situation and haven taken the opportunity to do so. Claims of critical theorists being unwilling to listen to voices of those most affected by current policies are addressed by listening to the voices of aromatherapists and the related health care practice, nursing.

Grounded theory methodology for data collection

Most scholars agree that there is no inherently critical method for collecting data (Fontana, 2004). Indeed critical theory can be combined with a wide variety of methodological strategies. Grounded theory is primarily a methodological strategy (Kushner & Morrow, 2003) that was originally structured around symbolic interaction showing how data can be collected and used to develop theory of social interaction. A critically interested grounded

theory methodology is intended to result in the generation of knowledge that contributes to meaningful understandings and explanations of human interaction in the social world these in turn potentially contribute to emancipatory transformation (Kushner & Morrow, 2003). Importantly grounded theory refers to the importance of going to the source for data that accurately reflects reality as it is now.

Grounded theory methodology allows the collection of data that is relevant, because the data is not preconceived and comes from the people involved thus it fits the situation and has grab for others (Glaser, 1998). Further grounded data empowers those in the situation as they can see the relevance (Glaser, 1998). By being relevant it will work, be meaningful and have value, via lasting contributions. Consequently the theory practice gap is addressed by grounding data in reality with data gathered from practitioners as well as literature.

Grounded theory has been especially useful for the study of setting and social relations that have not previously been the explicit focus of attention (Kushner & Morrow, 2003). In this study it was used to inform the process of gathering data providing insights by those involved in the process of professionalisation, enabling the generation of data that is relevant to those involved.

Researchers fundamental beliefs underpinning the study

My fundamental beliefs, as the researcher, are that: the relevant phenomena for the study are socially constructed, have multiple realities, are changeable and the present and future are built on the past. Further I believe the views of individuals are valuable for they influence the discourse that creates reality; that individuals have a right to their own view and choices; and there is meaning in the lived experience. Significantly I consider knowledge for its own sake to be of little value and thus ought to be used for morally right purposes, such as for the improvement of social wellbeing, empowerment and emancipation. Finally I believe that informed knowledgeable choice provides power as it enhances the ability to obtain one's desired outcome.

As an aromatherapist, both having practiced and taught it is impossible for me, as the researcher to stand aside all my knowledge, so I choose to use that knowledge to explore and look at alternatives for the development of aromatherapy. I believe in the value of the practice of aromatherapy and my scientific training shows me the value of scientific

principles. With greater understanding of the issues for the development of aromatherapy (and other CAM) practice it becomes possible to access the potential options for the practice and present them in an informed and relatively objective way.

Summary

In investigating the professionalisation of aromatherapy this study aims to systematically produce knowledge that is emancipatory in nature. It intends to provide support for occupational development. This study focuses on meaning rather than measurement whilst challenging assumptions and acknowledging the changing nature of the relevant knowledge, thus a qualitative methodology of a post-modern paradigm is required. As the meaning attributed to the institutions under investigation, health care, aromatherapy practice and professions are socially constructed, social interactionism is an influencing methodology. However as the study intends to produce knowledge that instigates social change it requires critical social theory as the primary methodology. Finally grounded theory methodology will be used to inform data collection in order to ensure the study is grounded in current relevant data. The choice of critical social theory influenced by social interactionism and grounded theory best 'fits' the study aims and thus will be used. The next chapter will outline the method used for the study.

Chapter 7

Method

(there are) only 3 methods for gathering data in social research. One can either listen to what people say, observe what they do, or conduct an historical inquiry. Therefore, method is only the technique used for data collection

Fontana, 2004

This study aims to instigate a liberating social change for the development of CAM occupations using the professionalisation of aromatherapy practices as a case study. This intention ensures that critical theory is the most suitable methodology for this study. The study methodology influences how the phenomena are approached, while the method is the technique used for data collection and processing. This chapter will describe the method used in this study. In selecting the method for this study it was important to consider the two distinct aspects of the study. The overriding critical theory and the process of gathering grounded data from the participants. The method for each aspect will be reviewed separately. The method used for developing the critical theory will be outlined and then the method for participant data collection and its processing will be described. The chapter will finish with ethical considerations and discuss issues of validity and reliability relevant to the study.

I Critical Social Science

Critical social science is the overriding methodology of the study, it reflects the overall conceptual approach of the inquiry, the way in which the phenomena are approached and interpreted (Fontana, 2004). Critical theory requires data that are both historical and current in nature (Fontana, 2004). Most scholars agree that critical theory does not have an inherent method for data collection (Fontana, 2004). Literature review was the method of choice used to develop an outline of historical and current data for context setting of the study as outlined in Part One. To ensure relevance of the data interviews were carried out to gather insights from individuals related to the study. Thus literature review and interviews were the methods used to gather data for the critical theory.

For the development of the critical theory Fay's (1987) guidelines of critical theory were used to guide how data was approached and interpreted. The guidelines use a basic scheme describing the requirements of a fully developed critical theory as consisting of a theory of false consciousness, a theory of crisis, a theory of education and a theory of transformation. These four theories have sub theories which Fay (1987) states are required to allow the full development of a critical theory. They construct a complex of theories that are systematically related to each other. These guidelines are outlined in Table VI.

Table VI

Fay's Critical Theory Basic Scheme: Fay provided this basic scheme stating that a critical theory must fulfil all the listed theories and subtheories.

I A theory of false consciousness which:
1 demonstrates the ways in which the self understanding of a group of people are false (in the sense of failing to account for the life experiences of the members of the group), or incoherent (because internally contradictory), or both. This is sometimes called an 'ideology-critique';
2 explains how the members of this group came to have these self-misunderstandings, and how they are maintained;
3 contrasts them with an alternative self-understanding, showing how this alternative is better.
II A theory of crisis which:
4 spells out what a social crisis is;
5 indicates how particular society is in such a crisis. This would require examining the felt dissatisfactions of a group of people and showing both that they threaten social cohesion and that they can not be alleviated given the basic organisation of the society and the self-understandings of its members;
6 provides an historical account of the development of this crisis partly in terms of the false consciousness of the members of the group and partly in terms of the structural bases of the society.
III A theory of education which:
7 offers an account of the conditions necessary and sufficient for the sort of enlightenment envisioned by the theory;
8 shows that given the current social situation these conditions are satisfied.
IV A theory of transformative action which:
9 isolates those aspects of a society which must be altered if the social crisis is to be resolved and the dissatisfaction of the members lessened;
10 details a plan of action indicating the people who are to be the 'carriers' of the anticipated social transformation and at least some general idea of how they might do this.

Sourced From Fay 1987 Critical Social Science pg 31-32

Significantly critical theorists utilise strategies to overcome resistance to the developed critical theory (Fay, 1987). Strategies used to reduce potential resistance were to ‘ground’ the theory in the audience’s own understandings and make it accessible by providing an ideology critique of the audience’s self-understanding and elaborating on why the false consciousness will not effectively continue. Thus to increase relevance of the developed critical theory members of the relevant occupational groups, aromatherapists and related health care workers, were interviewed. Data gathered from this process also enabled insights related to sub-theories of Fay’s guidelines to be gathered. The data obtained was interwoven with literature data allowing the data to be placed in the historical and structural context (Wainwright, 1997) providing a relevant and grounded critical theory.

II Grounded Participant Data

Grounded theory methodology was used to inform the source of participants, guide the data collection from them and for the initial processing of this data. Data processing was separate for each group, allowed the development of categories and themes from data until saturation was reached, saturation being the point where no new insights were being collected. The use of grounded theory method ceased at this stage. This allowed the development of grounded categories and themes but not a grounded theory, as the intention was to develop a critical theory using grounded data rather than a grounded theory.

Participants

In grounded theory open sampling is used to find potential participants (Chamberlain, 1995; Benton, 1996). One looks for participants where one is likely to find them, that is from individuals likely to have the data required. Thus the aim was to collect data directly from aromatherapists, nurses the most closely overlapping health care occupation and medical practitioners as the dominant health care provider. The last two groups were of interest because they represent members of occupations that are of great importance to the professionalisation of aromatherapy practice. Further it was also necessary for nurses and doctors to have knowledge on the topic of interest, aromatherapy, to ensure informed, relevant feedback.

Initially potential participants were recruited by personal contacts known to fit the group requirements of being trained in and or using aromatherapy in health care practice. These individuals were also asked to refer others. Various institutions were contacted for potential participants in attempts to extend the pool of potential participants. Participants in each group were recruited until saturation for that group was obtained, that is no further insights were being obtained. Details for recruiting each participant group are as follows.

Aromatherapists

As an aromatherapist I knew a number of aromatherapists professionally and they were the first contacts I made. I was looking for a broad group of practicing aromatherapists so the initial aromatherapists I approached included members of the aromatherapy professional associations in Australia, International Federation of Aromatherapy (IFA) and Australian Aromatic Medicine Association (AAMA). I contacted ten aromatherapists, of these three participated. I approached another five aromatherapists at an aromatherapy workshop, one participated. A further four aromatherapist were contacted via details obtained from aromatherapy journals, of these one participated. The most successful manner for sourcing aromatherapist participants was via referrals (snowballing) of eight contacts, seven participated. These referrals were primarily from participating aromatherapists, with one from an interested medical researcher. This gave a total of twelve participants from twenty-five contacts at which stage saturation had been achieved.

Reasons given for not participating included 'too busy' and an expressed concern of being misrepresented. One aromatherapist initially agreed, then questioned the 'scope of the research' prior to not being available to participate. The tendency to be 'suspicious' and concerned about the research of those not participating was significant enough for a group of aromatherapists referred to as the 'suspicious aromatherapists' to be formed. One participant also expressed concern however chose to participate after discussion. That I, the researcher was an aromatherapist was of some reassurance to this participant.

Aromatherapist participants were sourced nationally; six from Victoria, three from New South Wales, two from Queensland, and one from Western Australia. For the sake of uniformity in sampling, the intention had been to interview participants from Victoria only. However in order to obtain participants it became necessary to accept those that were

willing to participate. Of the twelve participants eleven were female and one male. They were sourced and interviewed between August and December 2003. All participants were practitioners, five were aromatherapy educators, two were in retail businesses and one didn't do bodywork, using essential oils orally in their practice. Six of the participants had done more than one aromatherapy course, with five having trained in UK. All participants used aromatherapy in their personal self-care and were keen to see aromatherapy part of the accepted health care system.

Nurses

As I was specifically looking for nurses interested in aromatherapy a selection process was used that allowed me to contact nurses working with aromatherapy, rather than nurses in general, thus targeting the appropriate source of participants as required for grounded theory. Initially nurses contacted were individuals known to fit the requirements of professionally being interested in aromatherapy. Of the four practicing nurses contacted three participated, the other whilst interested was unavailable. Ten were contacted via an aromatherapy educational centre that mailed out my introduction and information letters, three of these contacts participated. Finally participants were also asked if they could refer further individuals (snowballing effect). An aromatherapist interested in the study approached two nurses, and both nurses approached by the aromatherapist participated. This makes a total of 16 contacts and eight participants. All nurse participants were female each with their own nursing history and background. They are from a variety of rural and metropolitan areas of Victoria. Nurses were obtained and interviewed over a period of five week in August and October in 2003.

Of the eight participants five had more than 20 years experience in nursing, one was a unit manager, three were educators and four were ward staff. Six participants were attached to public hospitals, one a private hospital and one was not currently within the hospital system. The participants also covered a variety of environments including coronary care, aged care and midwifery. All eight participants were very positive in regards to aromatherapy in health care. All had some training in aromatherapy, one hadn't complete their course but planned to take it up again. Three have done more than one aromatherapy course and the others have a Diploma. All used aromatherapy at home in their personal

self-care in various ways (health, wellbeing, cosmetic/aesthetic, medicinally, energetically). Each had their own approach to integrating aromatherapy into their nursing work.

Medical Practitioners

Again the intention was to target medical practitioners that were interested in aromatherapy and thus targeting the source likely to provide the relevant information for the study as outlined in grounded theory. Pirotta and colleagues (2000b) reported finding that 4% (19/438) of medical practitioners in Victoria participating in their survey had trained in aromatherapy, with 17% indicating they thought aromatherapy was suitable for an aromatherapy trained GP to practice. With this in mind it was anticipated that it would be possible to find some GP participants. With no known professional contacts indirect methods were the primary contact method for this group.

After 12 mail outs, via an essential oil supplier two participants were obtained. One was an interested dietician, one a medical practitioner. Nurse participants did do some referrals, the number of referrals was not reported and no participants were obtained. Medical professional organisations were contacted directly and their website checked. The organisations were Australasian Integrative Medicine Association, Australasian Integrative Medicine Association and Australasian College of Nutritional and Environmental Medicine. From this, one contact was obtained however they were not willing to participate. With only one participant the medical practitioner group didn't meet sampling requirement and as a consequence was not included in the study.

Data collection

For the collection of social data one can either listen to what people say, observe what they do, or conduct a historical inquiry (Fontana, 2004). For up to date and relevant data the most appropriate method for collection of data is from participants by interview. The semi-structured interview was used to allow a focused in depth interview whilst maintaining direction and keeping communication as natural as possible. An active interviewer stance was taken by the researcher as a way of stimulating respondent's knowledge base, whilst allowing for conscious setting of boundaries within the interview (Holstein & Gubrium, 1995). All interviews were recorded with permission from each participant. Then transcripts were used to allow analysis of the data.

The Interview Guide was constructed to allow participants to provide information with minimal guidance (Cormack, 1996). It covered three broad areas, aromatherapy, aromatherapy as a profession and aromatherapy an ideal future. These predetermine areas of interest where to ensure necessary information was gathered. The first area was intended to gain insight into what aromatherapy is according to the participants, considering the identity crisis and the possibility that practitioners do have a defined understanding of aromatherapy as a practice. The second area was to address the issue of aromatherapy as a profession, do participants believe aromatherapy to be a profession if so what they understand a profession to be and consider criteria of a profession related to aromatherapy practice. The third area was to gain insight into the possibility that aromatherapy practitioners want recognition, what they want for the future, how aromatherapy might fit into the health care system and what any perceived obstacles or challenges for aromatherapy's development are. This was to support the development of relevant theory of education and allow for the development of an effective theory of transformation. The interview guide is in Appendix 1.

Data analysis

Data analysis began with and occurred in conjunction with interviewing until saturation was obtained. Data were processed using constant comparison method (Glaser & Strauss, 1967; Benton, 1996) which involved coding data and looking for similarities and differences to form a theme and checking to see if a theme was really more than one. The initial processing of the data was also informed by principles of pattern recognition as used for the discovery mode of grounded theory (Aritinian, 1986). The process of data analysis was strongly informed by inductive reasoning and awareness that looking for insights requires the acceptance that frequency is not in itself an indicator of importance (Kellehear, 1993).

However it would be inaccurate to state that a strict formula was used for the data analysis. As critical reflection of a rather pragmatic nature was utilised, similar to that discussed by Freshwater and Avis (2004) where the structure for analysis and interpretation remain symbolic and the researcher is free to be creative and to construct their own meaning and structures. This is to overcome the problem of relying on formulae or rule based approaches such that they distract from the decisions the researcher needs to make in the process. According to Freshwater and Avis (2004) it is not so much the means of

production of knowledge as the quality of reflection on the evidence and the creative attempt to weave beliefs based on that evidence into the totality of beliefs held by the community. Thus the data analysis included abductive process (Rolfe, 1997) and critical reflection (Freshwater & Avis, 2004).

The interview data were processed in the three sections, referred to as 'areas of interest': aromatherapy; aromatherapy as a profession and; aromatherapy an ideal future. These three sections are separated out into part one, two and three of the interview results. Within each area of interest some categories were predetermined as part of the interview structure, others categories develop directly or 'emerged' from the data. True to grounded theory the data was examined for themes, within each area of interest and category. Finally in order to reveal main concerns for each group, key words and issues were drawn out of the data, due to the prominence of the words and issues within the participant group.

Once a point of saturation occurred, for each group, the data from that group was considered completed for the study. Saturation of all the areas was not required, for area one on aromatherapy practice was so broad saturation in this area was difficult to obtain and its lack was considered as evidence of a lack of a clear definition of the practice. However in area two, aromatherapy as a profession, saturation was reached and were used to indicate saturation for the study.

Data feedback

The analysis of each participant group (aromatherapists and nurses) including the key words and issues was forwarded to all participants within the group. This was to gather feedback on the analysis allowing for clarification and validity of the analysed data. Six of the twelve aromatherapists responded to the first mail out, two further responses were obtained from a second mail out. One other aromatherapist participant phoned to apologise for not being able to respond, due to life circumstances, however did give some verbal feedback. This resulted in three of the twelve not responding to the feedback request. Note due to the diversity in the data the mail out was long and this may have contributed to the non-response. Six of the eight nurses responded to the first mail out. A second mail out resulted in one more response, leaving only one non-response. The feedback allowed for final adjustments to the data.

Final processing

The categories were summarised and ordered within each area of interest for presentation and to allow for ease of comparison between actor groups. Finally semiotic analysis was carried out with the intention of giving meaning to content as a reflection of deeper phenomena. Semiotic analysis looks for meaning beyond the obvious intention of the communicated data (Kellehear, 1993) providing a 'deeper interpretation' of the data and the experience of collecting the data allowing the uncovering of powerful processes not consciously expressed. To be able to interpret the data in this way required the researcher to understand respondents and the context.

II Validity, Reliability and Ethic Issues

Validity and reliability are terms and concepts used to verify the standard of quantitative research. Wainwright (1997) argues that in order to gain more scientific respectability from the dominant positivist biomedical model there has been a compromise in qualitative research due to a willingness to submit to the positivist criteria of reliability and validity. This compromise is because the use of reliability and validity violates the philosophy, purpose and intent of the qualitative paradigm (Leininger, 1994). As the nature of the qualitative research is different to quantitative research issues of reliability and validity ought to be addressed differently (Morse, 1994). Indeed it is generally accepted that the methods of assessing the validity and reliability of a scientific study depend on the nature of the research carried out.

In qualitative research reliability and validity are usually referred to as establishing adequacy of evidence and credibility (Chenitz & Swanson, 1986) with various criteria suggested (Leininger, 1994; Roberts & Taylor, 1998). However in critical theory validity is directly related to the stated purpose of the research, with the research being valid to the extent that it provides insight into the system of oppression and at a secondary level its usefulness to countering that oppression (Clark, 2003). Critical theory is thus evaluated by emancipatory implications, the stimulation of action for social transformation social justice and equity (Fay, 1987; Lincoln & Guba, 2000).

For this study going back to the source, as is required for grounded theory was used as a means to validate the findings from the interview data. This qualitative approach to validity served to ensure the relevance of the data assuming that what the participants said was real and trustworthy. Roberts and Taylor (1998) point out that qualitative research assumes that 'real and trustworthy' knowledge is found by paying attention to what people say and do, noting that truth is relative and 'context' dependent. Yet Wainwright (1997) argues that without a critical stance to the beliefs of the informants, all testimony is accorded equal status without any attempt to explain or inform the development of consciousness or consider their epistemological adequacy or emancipatory potential. He emphasised a need to consider how beliefs develop arguing that beliefs ought to be examined within the larger context of broader historical and structural analysis. It is from this aspect that the data was then used to assist the development of the critical theory.

Participant bias

A purposeful part of grounded theory methodology is the deliberate process of selecting participants with the intention of gaining insights that may not be gained from random sampling. This is why a focused selection of participants was utilised in this study, thus it is not a true bias. However whilst this focus group was intentional a self-selecting process by aromatherapists approached to participate was not, this resulted in the creation of a potential bias in sampling.

As previously mentioned during recruitment two groups of aromatherapists developed. A group labelled as suspicious¹⁰ and the participating group. The suspicious group, with one exception, self-selected not to participate. This is a concern for the study and the researcher due to the risk of loss of important and sort after views. By choosing not to participate the views of this group remains untold. It is possible that the aromatherapists not participating represent different view(s), other than the noted suspicion, to those that did participate. Such as why are the aromatherapists suspicious and concerned? This cannot be determined without greater insights from that group. Nor can it be assumed that they hold the same or corresponding views as the participating aromatherapist for clearly on at least one point they do not. As a consequence there maybe some questioning of the validity of the

¹⁰ Not all non participating aromatherapists were within this group. This group was formed from aromatherapists expressing suspicion toward the study and possible misrepresentation.

aromatherapist data, in that a full perspective may not have been obtained despite one participating member of the suspicious group.

Warrantable evidence

‘A fundamental assumption in science is that knowledge claims must be warranted, that is, criteria or evidence must be brought to bear to justify these knowledge claims.’ ‘Warrants are more than the procedures used to ensure rigor in scientific work. They are qualities of the evidence presented for a knowledge claim’ (Forbes et al., 1999). Three warrants for warrantable evidence are: the use of methodological strategies in common with accepted practice; evidence can be corroborated via reproducibility or cumulative consistency and; an adequate scope of evidence to address the phenomena under study (Forbes et al., 1999). In support of the evidence being considered warrantable, critical theory is an accepted methodology and the evidence presented is gathered from participants related to and with an interest in the view as well as from literature and is cumulatively consistent. Yet there is always room for increased scope of evidence and whilst the presented evidence meets the requirements of the methodologies used (critical theory and grounded theory) it is also true that further research and evidence would strengthen the evidence base.

Generalisability

Generalisation is not normally a concern for qualitative research, but this study aims to provide information that is focused on one group and then generalised to other related groups. This is because the intention is for the critical theory developed for aromatherapy practice to be generalised to the broader CAM occupations. It is important to note that it is the broader aspects of the theory and not the specific aspects that are considered for generalisation. That is the particular issues for aromatherapy practice may or may not be relevant to other CAM occupations however the general aspects of the two approaches to health care, professions, the professionalisation process and requirements of a occupation in health care are relevant, as are the issues that arise around them specifically related to CAM development in the Australian health care system.

The study is restricted to time and place with minimal generalisation being true to the view that within contemporary post-positivism generality of knowledge does not necessarily imply universality (Wainwright, 1997). Thus for this study ‘fittingness’ and ‘comparability’ are more appropriate terms to use. This is due to the revealing of the social

relations that underpin the process (Wainwright, 1997). The relevance of the information within and beyond the Australian health care system context will depend on the 'fit'.

Ethical issues

Ethics requires that the researcher ensures that the wellbeing of participants is appropriately considered and dealt with. General ethical issues are benevolence, informed consent, confidentiality and ethics approval. Further a researcher has a responsibility to seek knowledge, carry out research in a competent manner, to report results accurately, to manage available resources honestly, to acknowledge fairly those who contribute ideas, time or effort, to consider the consequences to society of a scientific endeavour and to speak out publicly on societal concerns that are related to a scientists specific knowledge and expertise (Shaugnessy & Zechmeister, 1990) as part of scientists integrity (Knafl, 1994). Thus researchers are required to attend to the best of their ability and consciously considering these issues through out the study, this was carried out.

No risks were perceived for participants. Further, all participants were communicated with from a space of respect and appreciation for each individuals comments. Informed consent was obtained from all participants. Prior to providing their consent all participants were informed of the purpose and requirements of the study. They were also informed that they may withdraw at any time, as their participation was voluntary. The informed consent form and information sheet are in Appendix 2.

Confidentiality and privacy were assured to all participants, both verbally and in writing. Further data was kept securely in a locked cabinet and will be kept for five years as required by the National Health and Medical Research Council guidelines. No deception was required in this study, though concerns of deception did need to be addressed when enrolling potential participants as noted by the aromatherapist suspicious group. Ethics approval was sort and obtained by the SCU Ethics Committee.

Summary

The method for this study is in two parts. First the over riding critical theory methodological using Fay's Critical Theory Basic Scheme. This required historical and

current literature data outlined in Part One and current data gathered from relevant health care participants. The second part of the method guided the collection and initial analysis of the data collected from participants. The purpose of this data collection was to give voice to those most affected and thus ground the study via obtained insights. This data also enabled the use of the strategies to overcome resistance to the critical theory developed. The method used for this aspect of the study was guided by grounded theory method for data collection and analysis. The next two chapters will outline the data collected before moving onto the discussion of the data and the development of the critical theory in Part Three.

Chapter 8

Aromatherapist Interview Results

The best way out of a problem is through it.
Proverb in Allen, 2003

This chapter presents the data from the 12 aromatherapists' interviews. The data has been organised to make it as accessible as possible, as there is quite a lot. Firstly researchers comments on collecting and processing the data will be noted, then the categories and themes within each of the three areas of interest are presented. The data itself will then be outlined. Finally a summary of the data, including key words; key issues and a statement on the interpretation of the deeper meaning will be presented.

I Aromatherapist Data Collection

Aromatherapists' interview data was diverse providing numerous insights, at the same time the commonalities of what they had to say were significant. The data were processed and is presented in three parts: data related to aromatherapy practice; data related to aromatherapy as a profession; and data related to the future of aromatherapy practice. The data are summarised in the analysis conclusion. 'Key words' and 'key issues' were noted as the dominant themes for the group and meaning beyond the obvious intended to be communicated was interpreted and noted as a 'deeper meaning'.

Researchers comments on processing aromatherapist data

As part of the process of doing this study I had to address personal reactions that were provoked. One that struck home the hardest was the experience of rejection I initially encountered. Comments such as *'I have contributed enough'* *'too busy'* and *'what is the scope of this study'* and *'I have been misrepresented by the media'* were consistently made and were interpreted as a lack of willingness to participate combined with suspicious inclinations. This experienced exposed a previously unconscious hope to improve the position of aromatherapists, my colleagues. I wanted recognition for aromatherapists as well as aromatherapy practice and its value. I re-grounded myself to the commitment of promoting the use of the essential oils, not necessarily in practice by aromatherapists. With persistence and over time aromatherapists choose to participate. There was still suspicions *'Who are you? What are you going to do with this data?'* *'I don't want this to be used against aromatherapy'*.

That I was an aromatherapist and willing to chat and share my story was reassuring for one aromatherapist. Other aromatherapists simply thanked me or acknowledged the value

This is very interesting to me, this whole conversation... some of the stuff you have asked. I've been dying to say for ages and frankly you're the first person to ask me (10-49)

thanks for taking on the challenge of attempting to take elements of everybody, common voice. It's a big job and responsibility. Standing for that, for our industry (4-16) and pleased to see the work being done

Other participants commented on having been '*stimulated*' to think on the issues, more than previously. I felt a deep responsibility to the participants and am deeply appreciative of their willingness to participate and trust me.

Aromatherapists that were contacted appeared to be of two orientations, a suspicious group and a group keen to participate. That primarily one group participated and the other not meant a potentially biased source. Importantly there was one participant that was suspicious at first and discussed their concerns providing important insight to that individual's concerns, specifically that the data might be used against aromatherapy. This in turn provided insights into the group that primarily did not participate.

I'm concerned about the nature of it and where it goes. I'm really really nervous about a situation where you take something new or a new idea and put it in front of a bunch of left brain academics and have them say 'OK what's wrong with this?' or conduct a survey in the way of 'What's wrong with this' or 'Wanting with this' as opposed to having a look at what people are doing with the art and I do think its an art. (10-1)

A second personal difficulty emerged as the data strongly showed a lack of clarity and confusion related to the knowledge base and its use. Aromatherapy as a profession didn't exist according to literature criteria despite the view of the majority of participating aromatherapists that aromatherapy was a profession. My intention to be true to the data, to support aromatherapy as best I could and to be respectful and uphold the trust the

participating aromatherapists had put in me initially caused an inner conflict for me. Due to the expressed concerns of the aromatherapists I was worried that they would feel the facts would betray them. However by facing the facts of a situation one is able to move forward and that is the essence of the study; facing reality and making informed choices for the betterment of the occupation. It was up to me, the researcher, the critical theorist, to present reality in such a way as to acknowledge the need for and inspire conscious action.

Table VII

Aromatherapist Categories and Themes: This table lists categories within each areas of interest and themes within each category as emerged from the data obtained from interviews with the 12 aromatherapist participants in the study. (R) indicates a researcher determined category and (P) indicates a category that evolved from the data.

Areas of Interest	Categories	Themes
Aromatherapy	Growing (R)	Dependent on use Needed for therapeutic use Government holding back
	Definition (R)	Uses (P)
	Public Perceptions (P)	Nice smell Dangerous No significant effect/dangerous
	Levels (P)	Multiple of use, diversity Need distinction Home use important
	Application Methods(R)	Multiple Primarily topical, however inconsistent views of efficacy for topical use. Inconsistent views of appropriate methods
	The Practice (P)	Differentiates and choice Offers more than books Educational support & treatment Focus on emotional/ body mind Communication important
	Holistic (R)	What is it Mind body spirit

II Aromatherapists' Data

Table VII 'Aromatherapists Categories and Themes,' shows the breakdown of the categories and the themes of each category, within the three areas of interest. Within the first two areas of interest, 'aromatherapy' and 'aromatherapy as a profession', whether each category was researcher (R) determined or emerged directly from the interview data (P) is indicated. All themes emerged from the interview data. In the third area of interest 'the future' three aspects, 'future', 'challenges' and 'what could be done' formed. It was determined that these aspects were too broad to be referred to as categories. The two first aspects 'future' and 'challenges' were researcher determined, the third 'what could be done' along with all categories and themes emerged from the interview data. This table is designed as an overview of the interview results, more information of each category and theme follows.

Area of interest 1: Aromatherapy

Growing in health care

While many participants believe that aromatherapy is growing, others are not so sure. *'The fact that it is growing is good, but whether it's growing in areas that truly make us credible...I don't know'* (8-15). It was suggested that any growth depended on the application and that growth was more related to changes related to commercialisation and a desire for natural products. It still has a way to go particularly regarding the therapeutic aspect of aromatherapy. On another track the view that the government was holding the growth of aromatherapy back was expressed.

Definition

The participants consistently gave the basic definition of aromatherapy as the 'use of essential oils (plant extracts) for health and wellbeing, body, mind and spirit' with very little variation. There was an emphasis on aromatherapy as a natural 'therapy' and that it is more than a nice smell or beauty therapy.

Aromatherapists also described aromatherapy in terms of what it is used for. It is used as a tool for management of health and wellbeing; as a therapeutic intervention, to both prevent and treat minor condition; for nurturing and stress management. This also lead to the

mentioning of the public perception and different levels of use, however these are mentioned as the separate following categories.

Public perception

Most participants indicated that they thought that aromatherapy is generally seen as

things that make the place smell nice and kind of calm you down, pleasure principle thing and there's that group that says OK we can cash in on this aromatherapy thing (10-12)

with a strong commercial lean resulting in aromatherapy practice not taken seriously. A second perception, that 'aromatherapy is dangerous particularly if pregnant' was also mentioned along with the dichotomy of no significant effect and yet potentially dangerous that this perception created:

two extremes, on one hand we say it's fluffy, it's just aromatising and the commercialism. At the same time it's interesting to watch patients coming in and say 'read somewhere I'm not allowed to have oils because I am pregnant (8-16)

Different levels of aromatherapy

Participants indicated that there are a number of levels of practice of aromatherapy: layperson; beauty therapy; massage; nursing; clinical; and internal. This multilevel use of aromatherapy gives it diversity, which is seen as an advantage. However it was also noted that clear distinctions between the levels would be valuable.

Dream come true, that a person who calls themselves an aromatherapist qualifies what they mean. Like say Diploma Aromatherapy, massage; Diploma Aromatherapy, therapeutic, clinical. (7-12).

It was indicated that the layperson or home use of aromatherapy was particularly important and valuable.

Methods of application

A number of methods of application were mentioned by the participants. Most of the participants consider topical application, of the essential oils, the primary method of application. However there is inconsistency on its believed effectiveness, particularly related to dilution of essential oil, for this method.

Two methods of application, oral and direct, undiluted application, had inconsistent views of appropriate use. While it was indicated that oral use is against IFA policy a number of participants do use it, at least on them self. One participant uses it as their primary method of application in their practice.

Aromatherapy the practice

Participants felt that

A professional aromatherapist has way more to offer than what the general public can read out of a book... (knowledge base?) yes and their life experience, the more clients you treat you learn more putting your knowledge into practice than you could ever learn out of a text book... Practitioners can treat. I've treated anything and everything over the years, even in the early years... Still can treat difficult imbalances quite effectively. (9-12).

As aromatherapists were seen to provide educational, well-being support and are able to treat presenting conditions.

Participants tended to indicate that practice focused on emotional and or body mind work and felt that communicating with the client was noted as an important responsibility, as was the appropriateness of referring on. *'As an aromatherapist I take great responsibility with having conversations with people today.'* (4-7)

Holistic

One participant clearly stated the term holistic is a problem

Holistic, it's a term that actually gives me the shits, 'cause I think it's bandied about. What is holistic, taking a handful of vitamins and eating wholemeal bread? (7-4)

However most agreed it was the *'... linking mind, body and spirit aspects to being a healthy whole person.'* (12) With some adding additional qualities including, natural products and finding the most appropriate approach for the client.

Area of interest 2: Aromatherapy a profession

Is aromatherapy a profession?

'Yes it certainly is a profession.' (8-31) most participants clearly thought of the practice of aromatherapy as a profession, while others were not so sure giving various reasons. One participant indicated *'the day it got into hospitals I'd see it as a profession.'* (11-11). A couple of participants thought that there was not the number of practitioners required for a profession.

Being seen as a profession

It was indicated that it was important for aromatherapy to be seen as a profession because *'I do I think it acknowledges recognition of what aromatherapy does.'* (12) A diversity of reasons for professionalising aromatherapy was indicated by the suggestion *'... everyone has their own barrel to push.'* (11-10)

What is a profession?

A profession was primarily seen as *'a mode of income, of making an income'* (7-8), practicing something trained to do. *'...it's a job that requires knowledge and training. It is a skilled job, therefore it is a profession.'* (6-14). However a variety of ideas were expressed for example

to me, anything that is a profession has ethics, it has growth, it has knowledge. That to me is a profession. Oh yes it (aromatherapy) has all of that, it is a profession, it is not a trade. A trade to me is nuts and bolts. You have a physical problem therefore there are only a couple of oils you can use...if it was a

trade then there would only be one or two solutions to a problem.

Like a plumber (2-13)

and *'...because it works. It works to some degree. To me a profession is carrying out something you absolutely love doing.'* (5-2)

Knowledge

Most participants express concerns of misinformation and contradictory information available to public and practitioners alike, including in some popular aromatherapy books and that there is a *'bit of room for improvement. There's conflicting information, safety ... within the industry there is some confusion and that needs fixing..'* (11-13) and

I suppose 95% is heavily plagiarized, not referenced, not scientific based, no validation. But, then when you do some high quality stuff like the IJA (International Journal of Aromatherapy) it's not well subscribed to either. Aromatherapists find it too high brow. (7-9)

suggesting that many aromatherapists are not comfortable with scientific knowledge. Others indicated that the knowledge base has grown and changed. While a couple of participants indicated there was value in and a requirement for using scientific knowledge. *'Doing a lot more research to justify how and why it works. That's good.'* (11-3)

Research

Many participants indicated there is a need for research on aromatherapy, but question how to go about it, expressing concerns regarding the scientific research method, who is going to do the research, will it take the essence out of aromatherapy practice (the life) and one participant questioned the value of the research model, relating to changes in practice requirements.

I think I want more research, I'm not saying there's not enough information for us to practice, but I guess I work within the boundaries of what is proven and realistic. It's not that there

isn't a knowledge base, it's that it could be improved upon. I would hope that everybody would want more knowledge. (6-15)

research everything down to the nth degree and would make it lifeless...robotic, awful ... They kicked the life out of it. (10-42)

Training

The response to questions regarding the training for aromatherapy highlighted a number of different views. Over all the view was that the current standard of accredited aromatherapy 'training level is adequate.' (1-13). However, a few participants suggested the practitioner courses could be improved, with some comments on course content, including understanding one's limits and referring on. Other participants questioned the relevance of the course contents and concerns over short courses, particularly if course participants started practicing aromatherapy after completing them.

Training is an issue. Lots of two day courses, say aromatherapist. This is not an aromatherapist. Maybe OK for a beautician, where they add several drops of the essential oil to face mask, toner. That's not aromatherapy, they do have their role. (3-2)

Distinguishing between the course types was seen as important. Concern over being part of beauty therapy training was expressed. There were a couple of comments on aromatherapy as an adjunct to other training or professions. There was comment on the appropriateness of different levels of training, for different levels of use of aromatherapy, including the public. Finally the idea that regulation would be valuable was also put forward.

The general public don't know the difference (in courses) that's the problem. We need to raise awareness on what's a qualified practitioner and what's not. (9-9)

It was suggested that the standard of aromatherapy training would continue to develop and that eventually it would become a degree course at a university. It was indicated that a

degree course would be preferred for the oral use of aromatherapy, though some participants felt this level of training was not required.

Value

The value of aromatherapy is primarily associated to its complementary nature. It is seen as complementary to orthodox medicine related to its perceived ability to make contributions that orthodox medicine doesn't, for example caring, bonding, dealing with emotional aspects and for use in personal development. *'because you have the time to deal with what it is to move into wellness, rather than focus on OK what's the problem.'* (10-37)

I think it creates, can create, if used in an appropriate way it can create bonding...there's care to many children, babies. Many children don't get that... there is that sort of component (3-13)

While some participants acknowledged the value of orthodox medicine, some participants brought up issues of how they felt the medical profession failed to meet individuals needs and that individuals now 'doctor shop' to meet their needs. The complementary nature of aromatherapy filled this lack and contributed to creating a more holistic approach to health care. *'Is complement to orthodox medicine, but also alternative.'* (2-2) Aromatherapy is also believed to provide, in some cases, a natural safer 'alternative for some things, but... always going to need a doctor. Can be used as an alternative to everyday' (1-1)

A significant contribution was seen as its role in preventative health care, which is considered to empower individuals in personal health care, for example by maintenance, wellness and stress management and has the potential to *'take the pressure off the health care system.'* (3-13)

even just that (prevention) is huge and the fact that people feel more in charge of their destiny and body is very empowering to them. They're more likely to stay well longer. (2-16)
huge prevention, you can bring down the national bloody medical bill overnight, if tap government into encouraging people to preventative. That's the secret to everything. (9-11)

Finally choice as an option related to personal preference and by the provision of supportive empowering information was considered a valuable contribution of aromatherapy practice.

I am a great supporter of people being informed, so I think people should do all that they can to be informed about their personal health and well-being. Support everybody being completely proactive, empowerment through informed choices.
(4-13)

I think it is important that people have the choice. (3-2)

Risk

Overall participants considered aromatherapy to be a relatively

low risk, unless you drink a bottle. I mean the external application or sniffing it. The amount that is actually absorbed is not enough to cause any serious side effects or problems. (11-14)

when used appropriately. However there was some expression of concern of risk particularly related to pregnancy, misuse of oils, irritations and incorrect or poor information provided. *'I think a lot of people have no idea how toxic the oils can be.'* (10-31).

Associations

Feedback from participants was primarily related to IFA (AAMA was not mentioned). The association was seen to play an important role in the professionalisation of aromatherapy. However, general dissatisfaction was expressed regarding the direction of aromatherapy's future, need for and lack of promotion, lack of support of members, unity and memberships numbers.

There needs to be, in Australia, a board of people who are actively wanting to promote and get aromatherapy recognized... I did not know there was an Australian branch (of IFA)... I don't know if that's due to my lack of awareness or whether it's a lack

of their activity. Maybe they need to have more promotion. I guess it's a funding issue. (3-14)

I think they have totally let us down,... we just hand over our money every year...I think a firmer hand on the tiller would help, but how to get that now? They almost need a year full time and be paid for it, but then they'd put the fees up. I think if I knew we would have a surer hand on the tiller I would welcome increased fees so they get some sort of remuneration so they could do their job. (12-28)

It's (IFA) seriously failing to connect with the promotion of it (aromatherapy) as a profession and that's what your whole thing is about isn't it...to get registered, to actually put it at the forefront of complementary medicine. Or at least educate the public or orthodox medicine in some of the benefits. (12)

Area of interest 3: Future

Ideal future

Overall participants were keen to see aromatherapy recognised or '*taken probably more seriously and probably more therapeutic aspects of it acknowledged by health practitioners*' (8-39) and '*would like to see more in health care.*' (2-7) where it can provide another option in health care. Participants also indicated that they would like:

clear guidelines for general use, better information, more aromatherapists actually working in the profession and being properly remunerated for what they do, clearer indications for how helpful the essential oils can be. I think in all aspects of life. (12-22) and

I would like to see more information out there for the general public, when its ok to use it at home and when they need to go and see a practitioner. And I guess that's where the training, I would like to see public education. (6-18)

It was also indicated that a central body *'There needs to be a working together of the various aspects of medical, beautician type. They need to work together. Central body.'* (3-15) and raised standards would be valuable.

Challenges

When asked about possible challenge or obstacles to aromatherapy moving forward a number of issues were raised, they were categories with their own themes:

Quality of essential oils

The variation in the quality of essential oils commercially available and the lack of a means to distinguish between them was seen as a major challenge for the forward movement of aromatherapy. The perceived consequence of this was that if someone used a poor quality essential oil and got poor results this lead to them perceiving aromatherapy of having little if any therapeutic value.

The issue was related to: the availability of synthetic oils; that essential oils didn't need to be registered/listed with the TGA; that if they were registered/listed there was no regulation or distinction related to the quality/grading of the essential oil so registered/listed; the cost of good quality essential oils is higher and getting people to understand and determine which is the most appropriate essential oil to purchase.

Oh they're more concerned with how you bottle and label than with what is in the bottle...not everybody has to comply with those standards I don't think TGA is that concerned about the quality of the oil in the bottle. (2-12/13)

Government

The government was perceived to be a major challenge for aromatherapy's development, with a number of aspects indicated. There was expressed concern that the government was more interested in revenue than understanding the essential oil.

It was noted that there were members of the government that actively put aromatherapy down. At the same time other sections of the government was open and supportive of aromatherapy. The overall recognition and understanding of aromatherapy or willingness to be open to aromatherapy's potential value was considered to be lacking by the government. There was expressed concern over matters raised due to the 'Pan debacle' and its effect on natural therapy industry as a whole. The bureaucracy of dealing with the government was perceived as an issue.

Questions regarding government support for research into aromatherapy were raised. It was also expressed that the government would actually need to take some action as the public was turning to natural therapies, such as aromatherapy, and this would require being catered to.

The bureaucracy require to know whether this is wellbeing stuff, therapeutic stuff, which category to put it in.... OK, then that whole program cannot be approved. How do they justify any cost? Reason for having you there in the first place and how do they get insurance for it? (10-9/10)

So where are we going to get that sort of support, at a practical level. They are happy to tax us equally, but we don't get that support (funding for research). (8-41)

Distinction

The lack of clear distinctions between the different levels of aromatherapy and therapeutic and commercial aspects of aromatherapy were seen as obstacles for the development of aromatherapy in Australian health care.

Distinctions, we need a universal decision There's no distinctions and people don't know and that's why they're frighten to use them, all about education. (5-4)

Regulation

Participants expressed a couple of points regarding the regulation of aromatherapy. First, the idea that aromatherapists maybe regulated out of business and the essence of aromatherapy practice would be lost, especially if the essential oils were to become recognised for their believed therapeutic value. At the same time there was an expressed wish to regulate who could practice aromatherapy, related to concerns over risk due to inadequately trained practitioners. Thirdly, it was suggested that some essential oils ought not be available to the general public. Finally, one participant pointed out the difficulty of regulating aromatherapy. *'How, when, why regulations' (1-17).*

I have this horror of being legislated out of existence...there will be government guidelines and bureaucracies looking over your shoulder and this kind of thing, because essentially it's a healing tool. (10-14)

Health care integration

The process of integrating aromatherapy into the health care system was seen as an obstacle in and of itself. Mentioned issues include getting everyone working as a team, keeping a balance and becoming evidence based. *'Getting different health care professionals to work together.'* (6-19)

Medical practitioners

Participants indicated they felt dealing with medical dominance, obtaining recognition and acceptance by the medical profession was a challenge to the development of aromatherapy. Some participants put forward that certain doctors feel threatened by natural therapies, including aromatherapy. While, other participants felt some doctors are supporting aromatherapy and natural therapies. One participant indicating that they felt that there was far more over lap between the two approaches to health care, natural and orthodox, than

some people are aware. Finally it was stated that the medical profession is aware that natural therapies are 'here to stay' and accepting of them.

Orthodox medicine concerned about natural therapies in general you know I think they're a bit afraid of them, or are unsure of what they are and how they work and I think that's a mind set. (12-23)

There are some doctors here who think aromatherapy and general healing is marvellous and there are others who just think it's a bunch of boloney (10-3)

I think that natural medicine and aromatherapy are starting to be acknowledged. What they think of us differs between different people. I do think that the health profession, we're recognised as being here to stay. (6-10)

Pharmaceutical

Some participants indicated that they felt that

we have a big problem with pharmaceutical companies ... because I'm a bit of a conspiracy person and the whole Pan pharmaceutical things like that... There is never going to be the money for them to make out of it, so I think they will always slow the system down... sad reality. (9-20)

Pharmaceutical companies aren't going to investigate what they can't patent, they can't exploit, they can't promote as their own product (3-1)

Aromatherapists

There was some expressed concern over the lack of unity and the apathy of aromatherapists in general, with this being a challenge for the development for aromatherapy.

Well at the moment the challenge to aromatherapy is the aromatherapists themselves' (7-12)

I think people are doing their own thing, there isn't really a block of people, really, who are into making that more serious part happen. The united front is plagued with the usual problems of a committee (10-45)

I don't know whether, as a group of therapist, we are united enough to change the way. I think it's nice that Australia is radical enough to lead the way, but are we leaders or followers? (8-8)

Lack of Funds

'Lack of funds in the industry to promote itself' (11-15) was considered be an obstacle to tackle the required actions.

What could do

Uniting

Getting on board with the medical professions, education of doctors and public alike, to promote aromatherapy and its therapeutic value were seen as an important steps to assist in the development of aromatherapy practice in health care.

I think if we get on board with doctors and get the health care professions to recognize us I think that's the way to go. Because people have respect for the health care profession. If doctors say that's the way to go, then they'll do it. It's a way of educating them (the public). Just that it is going to take so much time. (9-20)

I think to be taken seriously, I hear that Monash University, where they teach medical students, somewhere in their training

their actually having sessions in meditation. Why can't we infiltrate at that level? (8-8)

Other Expressed Concerns

Earning potential

'I think a lot of people are struggling to earn money within the profession. It's really hard, very hard to make a decent sort of money.' (12) Practicing aromatherapy was seen as a difficult way to earn a living. Many participants improved their income by combining aromatherapy practice with another source of income such as teaching, retail and multimodal practice. *'I'm not just an aromatherapist, I practice other modalities...knew a long time ago, it was not enough for me to survive with that as my training.'* (8-40). Some participants pointed out that practicing aromatherapy was a *'life style choice, (and) satisfaction'* (8-34) in one's work was more important than earning a significant income.

Course cost

The cost of training as an aromatherapist drew a few comments, *'I also think it's frightfully expensive. One lass was telling me a private college here to do an aromatherapy diploma was going to cost her the best part of ten grand. I said 'what!'* (7-6)

Aromatherapists' key words:

complementary, therapeutic, preventative, integrative

Aromatherapists' key issues:

Lack of recognition and understanding, lack of distinction between levels of aromatherapy and quality of essential oils, the commercialization of aromatherapy, the quality of the knowledge base, the need for research, but how to, concerns of being regulated out of a job, and risk of the essence of aromatherapy being lost.

Aromatherapists' deeper meaning:

It was apparent that there is concern for the recognition of aromatherapy practice as a distinct and valuable health care practice as well as concerns regarding the opportunity to practice and earn a living in the field. There appeared to be a concern that the distinctiveness and practice of aromatherapy practice will be lost if the occupation does

what they are being asked to do to fit in. There is a sense of a ‘damn if we do and damn if we don’t’.

Summary

In this chapter the data from the aromatherapist participants has been presented. Aromatherapist participants defined aromatherapy as ‘the use of essential oils for health and wellbeing’, noting that there is a number of levels of use of aromatherapy. Aromatherapists expressed the view that aromatherapy appears to be related to commercialisation and associated to ‘a nice smell’ and ‘beauty therapy’ with the result that the therapeutic nature of aromatherapy practice is not well recognized. The data also revealed that there is currently a lack of clear distinctions between the levels nor is there unity on the how the essential oils are used in aromatherapy practice. Aromatherapy practice is believed to be a profession by participants.

Aromatherapist participants were keen to see aromatherapy practice develop within the health care system. They acknowledged that research is required to develop the practice’s knowledge base and obtain recognition however concerns on the appropriateness of scientific research for aromatherapy practice were expressed resulted in a double bind situation adding to the felt dissatisfaction experienced due to lack of recognition for the practices therapeutic qualities.

The value of aromatherapy practice was primarily related to its complementary and preventative nature. Its holistic approach to health care, empowering nature providing choice and the potential of reduced cost and burden on the health care system were also seen as significant values. Aromatherapy associations were seen to play an important role in the professionalisation of aromatherapy practice, unfortunately the overall impression was that the associations were not fulfilling their role.

The expressed ideal future for aromatherapy practice was described as aromatherapy practice with clear distinctions between levels of practice, increased awareness of the multiple levels of aromatherapy practice and its value and the successfully integrated into the Australian health care system. Clear guidelines of practice, increased standards and a

central body, were also indicated as valuable contributions for the future of aromatherapy practice. Over all aromatherapists' have a strong belief in the value of aromatherapy practice for improved health care services but are concerned about the process of development both for the integrity of the practice and for securing their, as practitioners, source of income.

Chapter 9

Nurse Interview Results

It is demanding to try to understand people who engage with life differently from the way we do. But it can also be fascinating and hugely instructive.

Dowrick, 1997; 259

The desire for connection and caring is so compelling that many will pay out of their own pocket in order to have their needs met.

Ornish, 1998; 6

This chapter presents the data from the nurses' interviews, providing the insights from a related health care practice on aromatherapy practice in health care. As for the aromatherapists' interview data, the data from the 8 nurses' interviews are presented in three sections: aromatherapy, aromatherapy as profession and future. As with the aromatherapists' data the data is presented firstly by noting the researcher's comments on collecting and processing the data followed by a table summarising the categories and themes within each of the three areas of interest. Then the data summary is presented, prior to the key words, key issues, deeper meaning/interpretation and finally the summary of the data.

I Nurse Data Collection

Primarily participating nurses were united in their comments however there were a couple of exceptions. A selection of their comments including from their feedback, are included in *italics*. As for aromatherapists the data are summarised in the conclusion. Key words and issues were noted as the dominant themes for the group and meaning beyond the obvious intended to be communicated was noted in deeper meaning as an interpretation of the data.

Researcher's comments on processing nurse data

Overall the nurses were keen and enthusiastic to participate, some making great efforts to be involved. All were keen on the use of aromatherapy in nursing practice. My overall perception is that the nurses that were involved in this study are all very passionate about integrating aromatherapy into the Australian health care system. Most of the participants stood out as women confident in their proactive role and ability to introduce aromatherapy into their practice. This can be seen as a reflection of a biased group of nurses as they were known to be nurses interested in aromatherapy. However this was the target group and it is acknowledged that not all nurses are interested or supportive of aromatherapy in nursing.

II Nurse's Data

Table VIII 'Nurse Category and Themes,' shows the breakdown of the categories and themes of each category in the three areas of interest giving an over view of the nurses' interview data. Again the first two areas of interest 'aromatherapy' and 'aromatherapy as a

profession' had both researcher determined (R) and emergent (P) categories. However the third area of interest did not develop into aspects, as did the aromatherapist data. Rather of the three categories that emerged two matched two of the broad aspects, 'future' and 'challenges' that were determined by the researcher however the third category emerged from the data as did all the themes.

Area of Interest 1: Aromatherapy

Growing in healthcare

The primarily consensus was that aromatherapy use was growing. There was consensus that this trend of growth was a good thing and that there was '*a world of potential*' for aromatherapy and that it was important for the

bigger picture...The use of aromatherapy in the hospital setting, allows the introduction of complementary therapies in general which allows individuals to continue their personal practices, promoting real choice in health care and respect for the individual and their own practices. (8-3)

The data indicated that the growth of aromatherapy in health care in a particular setting depended on the management of that setting. In one case the change of management allowed for its introduction. At the same time there was expressed concern that it might not be growing in the way that was desired (therapeutically) due to the idea that it was '*perceived as a nice smelly thing rather than a therapeutic practice*' (5-3). Which was seen as '*another reason to improve the evidence base and quality of the training*' (AF)

Definition

The eight nurse participants were united, with slight variations in terminology, in the belief that aromatherapy is '*the therapeutic use of essential oils, plant extracts, for health and well being, physically emotionally and spiritually*' (1), '*suitable for specific conditions or symptoms*' (2). The skilled and controlled use was an important addition for one participant. All participants agreed that aromatherapy included a beauty aspect, in addition to this, participants emphasised that aromatherapy was much more, with multiple levels of practice and both holistic and therapeutic qualities.

Table VIII

Nurse Categories and Themes: This table lists categories within each areas of interest and themes within each category that emerged from the data obtained from interviews with the 8 nurses participants in the study. (R) indicates a researcher determined category and (P) indicates a category that evolved from the data.

Areas of Interest	Categories	Themes
Aromatherapy	<p>Growing (R)</p> <p>Definition (R)</p> <p>Essential Oils (P)</p> <p>Application Methods(R)</p> <p>Holistic (R)</p> <p>Framework (R)</p> <p>Introduction Process (P)</p>	<p>Yes</p> <p>Context dependent</p> <p>Not as liked</p> <p>Quality</p> <p>Appropriate use policy</p> <p>Appropriate labelling</p> <p>Available</p> <p>Appropriate training</p> <p>Range fine</p> <p>Massage restricting</p> <p>Mind body spirit</p> <p>Plus environment</p> <p>Interconnection</p> <p>Spirituality</p> <p>Beyond biomedicine</p> <p>Complementary to biomedicine</p> <p>Alternative within biomedicine</p> <p>Gradual</p> <p>Professional</p> <p>Within dominate paradigm</p> <p>Resistance</p>
Aromatherapy a Profession	<p>A Profession? (R)</p> <p>What is a profession?</p> <p>Knowledge base (R)</p> <p>Training (R)</p> <p>Value (R)</p> <p>Risk (R)</p> <p>Therapeutic effect (P)</p> <p>Scope of Practice (P)</p> <p>Associations (P)</p>	<p>Mixed</p> <p>Professionalisation</p> <p>Specific requirements</p> <p>Paid employment</p> <p>Confusion</p> <p>Research needed</p> <p>Value traditional</p> <p>Quality required</p> <p>Credibility</p> <p>Appropriate</p> <p>Distinguish between</p> <p>Tertiary</p> <p>In medical /nursing</p> <p>Number listed</p> <p>Low</p> <p>Oral</p> <p>Yes, degree vary</p> <p>Diverse</p> <p>Lacked clarity</p> <p>Criticised</p> <p>Rival</p> <p>Conflict</p>

Future	Future	Increased recognition
		Integrated
		Choice
		Medical training
	Challenges	Available
		Knowledge
		Awareness
		Practice Clarification
		Presentation
	Other Issues	TGA
		Attitudes

Essential oils

All participants indicated that quality therapeutic essential oils are required. A couple of participants noted that any nice smells could be therapeutic in the sense that it may assist relaxation. However, only therapeutic quality essential oils are used in aromatherapy because there is '*... more to aromatherapy than a nice smell*' (1).

Further, it was also the belief of a couple of participants that essential oils should have an appropriate use policy and be used under the principles of '*quality use of medicines*' (3), and '(In hospital) *essential oils need to be controlled and monitored like any other medication*' (8-7). because they are therapeutic and ought to be treated as such. Another participant highlighted the need for control relating to labelling. However these comments also draw the feedback that this was '*a bit extreme-what type of medicines*' (AF) and '*true to a degree, but can't get too carries away so that people get 'scared' of what essential oils they can use*'. (AF)

Participants want to see essential oil available to all believing that it is '*important that they are available for everybody*'(2-6).

Application methods

Most of the participants have or do use the essential oils undiluted, direct and orally, even though they are considered controversial methods of application. None of the nurse participants used the essential oils orally with clients, noting a lack of adequate training to feel competent and comfortable extending the use beyond their personal use. In principle 7 of the 8 participants supported the use of the essential oils by any application method,

including the controversial oral '*...ok, after all essential oils are in foods and conventional medicines and evidence that oral use is dangerous simply isn't there*'(3) and direct methods '*provided the person is trained and competent, essential oils are used with intention and outcomes monitored*' (3-2). The 8th participant was against direct and oral use arguing there was not enough evidence to support its use. This participant also noted that when

working in nursing, if going to have a reaction, the reaction is going to be worse And evidence to support the essential oil use in this way is lacking... is particularly relevant in nursing, because I work with the frail elderly. I believe it wise to take a cautious approach in keeping with my duty of care and responsibilities as a team leader. (4).

Feedback comments to these comments were numerous stating '*I disagree there is much evidence in Europe.*' '*this person needs to look further*' and

have an issue with this evidence based approach. Where there is clinical evidence ie prolonged experience with essential oil in practice, that can provide guidelines for use using the evidence based approach is applying a mechanical reductionist framework which is problematic for holistic therapies

The over all view was that whilst massage is useful application, aromatherapy is limited if restricted to massage application. However appropriate training for each application method was considered essential.

Holistic

Whilst it was noted that there is some question of what holism is definitions were presented. The most frequently presented ideas of holistic practise were the 'mind body and spirit' aspect of the person generally expanding it to include the '*social and environment or ecomap*' (3-8). '*Everything you are doing impacts on everything else, beyond body and mind, what else are you doing?*' (8-3) With the overall view that the '*important thing is being aware a person has other dimensions, rather than just a physical being*'(2-5). Noting

the importance of being aware of the multiple dimensions and recognising the interconnectedness and that despite the fact that one *'can't necessarily change'* something, rather one *'can take (it) into account.'* (3-8)

Spirituality was raised as a point of issue. It was described as being about *'centring, grounding, energy channels, all part of whole, even if not conscious of it'* and a way of tapping into intuition. Spirituality was described as *'hard to define, persons spirituality, incorporated in emotional wellbeing, sense of purpose, direction in life'* (2-5). It was stated that *'spirituality is not about religion'*(3-7) rather it was about a sense of purpose and life direction. The spiritual side was also described as a 'grey' area, *'a bit interesting...airy fairy, vague...explanations are not forth coming'* (5-11) such that some find it challenging to appreciate.

Framework

Most nurse participants believe aromatherapy is complementary to medical health care as it *'uses medical framework, but goes beyond, it is a complement. Not alterative, to me alternative is separate'* (2-4.) Indicated that aromatherapy operates within and beyond the medical framework being *'...differed from the medical framework in that it was not a quick fix and required the individuals to take some responsibility for the own health'* (7-9)

and *'it is a slant on medical approach, using a different modality... complementary all therapies have there place...integrative approach.'* (7-9). It was seen as important that aromatherapy practice was within and complementary to the dominant system.

Aromatherapy was described as embracing the *'wellness model, addressing preventative and quality of life issues.'* However some felt aromatherapy is an *'alternative but talk in terms of complementary because the term is less threatening...essential oils are alternative to medications'* (1-5/6) thus is an alternative choice within the dominant health care paradigm. Or alternatively that aromatherapy practice is *'not really (beyond medical) if it is used therapeutically'* (AF). Over all the emphasis was that aromatherapy is ideally part of an integrative system of care, allowing real choice in health care with respect for individual's preference.

Introduction process

A number of participants expressed '*concern over the lack of professionalism in the way some nurses just order the essential oils and start using them.*' (8-2) Thus a professional approach to the process of introducing aromatherapy was considered vital, with care and responsibility primary issues. Specific issues raised included proper thought before implementing; the use of appropriate paper work, including intake forms, policy and procedures; gaining permission, risk management and the control of the essential oils as medicines.

One participant stated it was '*very important to consider(the) culture working with*' (5/14) and to work within the dominant paradigm, both of health care and community. This participant felt that it is important to deal with concerns of the medical profession, such as referring to aromatherapy as 'complementary care' rather than challenging the medical therapy realm directly allowed for easier introduction. Also by having a scientific emphasis including research for evidence based practice and addressing cultural concerns of the patients.

Another comment was that the '*development of aromatherapy will increase if (a) gradual*' (9/14) introduction of the practice was taken by those instigating its use, emphasising the need to avoid incidents that would provide fuel for the opposition. There was expressed concern that even a minor '*mistake and the whole thing could come crushing down*' (4) thus having significant potential of harm for aromatherapy's development.

Participants pointed out that it is important to note that not all nurses or medical staff are of the same view (aromatherapy is a valuable modality) and that there is always resistance to change. Consequently some resistance is to be expected with any attempt to integrate aromatherapy into the nursing practice, reinforcing the expressed need to work with the system. Indeed most had encountered some degree of resistance from colleagues.

Area of Interest 2: Aromatherapy as a Profession

Primarily aromatherapy was seen as a profession, though one participant indicated that they were not aware of the differences between an occupation and a profession and another two

indicated it was not a profession and expressed the idea that while they would like to see aromatherapy as a profession. One of these participants followed this with comments on the professionalisation process, indicating it was *'a long and hard process'* that required *'people at the top to drive it'* and *'mentoring'*. With nursing *'a very good arena for taking aromatherapy forward'* as nursing is able to provide mentoring and having *'fostered in a range of natural therapies'*. It was also expressed that the professionalisation process would *'force aromatherapy to confront education issues'*.(6)

What is a profession?

Some participants indicated their awareness that there was a requirement of a professional association, accountability, level of skill and knowledge, standards and codes of practice and standards of training. Other participants tended to think more in terms of paid employment one stating *'anything is a profession if it is what you do as a job'* (5-10)

Knowledge

Participants expressed concern over the myths of contraindications, the inconsistency of, misinformation and confusion of the knowledge. It was considered that misinformation was a greater risk to individuals and the practice of aromatherapy, than the practice itself. The need for good quality research to develop and clarify aromatherapy knowledge was emphasised. Typical comments were

'there is much anecdotal work but need research with aromatherapists involved, but aromatherapists don't know how, don't feel comfortable doing it' (2-8) *'Increased knowledge for increased safety and credibility,'* (2-3) *'working in environment of evidence based knowledge, do need to improve'* (3-1) *'essential to have quality research but the methods needs to suit the question. It is a concern that many teachers do not know how to assess the quality of research when it does exist or how to access it'*(FA).

Participants also pointed out that scientific research *'doesn't discount traditional knowledge'* (3-9) acknowledging the value of both knowledge types.

Training

There were varying opinions of the current training in aromatherapy. While some felt '*current courses are adequate*' many felt that the course were not. A core issue was that the '*curriculum is a greater issue than the education standard*' due to a strong concern on the quality of training. Another was that evidence based presentations would give aromatherapy more credibility and that there was a '*need to met national training standards*'. Many felt that for health care use of aromatherapy practice it was necessary to include addition elements such as '*awareness of health care system*',

amazed counselling is not part of the training...need more path(ology) and physiology(1/10), critical thinking is important for aromatherapy, assessing research data and aromatherapy knowledge and being open to questions on feasibility of data being presented as fact(6/2) Yes! Agree Take out 'business' unit or put as option. Suppose to be training for safe aromatherapy practice- not to set up a business, training and regulation about protecting the public. (AF)

Another view was '*don't know if adequate, but university courses would be better.*'

This was suggested so that aromatherapy practice would be inline with other health care practices in regards to training level and research in aromatherapy will benefit if aromatherapy does become part of the tertiary environment.

Agree but could still provide short courses for nurses eg use of essential oils for stress management and relaxation. I don't think nurses should have to do a second bachelors degree to be aromatherapists in a defined way. Another short course could be aromatherapy for wound management and infection. This could be at a cert. level and specially designed for nurses.(AF)

The idea was that aromatherapy practice's development would be held back if it did not move up to tertiary level training. It was acknowledged that it might take time for

aromatherapy to reach this stage. Importantly the need to meet *'different criteria if move to tertiary level'*, was pointed out by one participant. Others felt tertiary training was *'not necessarily (better) but that is where the curriculum and assessment experts are'* (AF) and *'don't agree this is necessary. Tertiary level of study always equates with lack of practical experience.'* (AF)

It was expressed by a number of participants that they *'Would like to see (aromatherapy) in medical, nursing training'*. One participant mentioned that it was *'an advantage for the aromatherapist'* to be trained in nursing or health care. Another participant noted that *'clients would like it better if aromatherapists had relevant knowledge such as midwifery.'* Others noted that aromatherapy is included in some nursing elective units on complementary therapies. One participant was clear on their goal to develop a nursing aromatherapy short course that was accredited with appropriate nursing and aromatherapy bodies.

The key focus was to match the training with the intended outcome of the course. Guidelines related to the scope of practice for any particular course. A need for the multilevel approach to knowledge and training level related to scope of practice and was seen to directly relate to the diversity of aromatherapy practice. Distinguishing between self-care courses for the general public and practitioner course was also considered an important step for clarifying aromatherapy courses especially if intending to do prescriptive or oral use of the essential oils.

Value

The value of aromatherapy was seen to vary with how it was used therapeutically, with the following potential values mentioned:

- 1) May help individuals take more responsibility for their own healthcare and beyond, moving into quality of life and personal development.
- 2) May be used to increase family involvement in patient care.
- 3) The provision of an option of choice. This was seen as an important value as it increased respect for individuals right of choice in health care.
- 4) Used as a preventative.
- 5) Used in a holistic sense, moving treatments away from the purely physical aspects.

- 6) Reduced drug use and the amount of side effects from specific drugs used and /or drug overload, or indirectly, for example reduced incidents of falls in elderly patients or drug resistant bacteria.
- 7) Reduced duration in hospital.
- 8) Increased positive care and public relations.
- 9) For staff care self care. Aspects mentioned included improved self esteem, because patients are easier to manage, obtain positive feed back from relatives, administration, public and self care on the job.
- 10) Opens the question of what is medicine.

Risk

Overall aromatherapy was considered a low risk therapy, especially when *'used as it is meant to be'*. A number of participants refer to the risk of aromatherapy as being less than some everyday products in the home such as candles and cleaners. There was difference in opinion with regard to oral use, some stating it had more risk, another pointed out there was no evidence for this view and that the *'adverse effects that have occurred have been deliberate misuse...don't think you can base safety on that sort of evidence'* (11/16) It was acknowledged that *'Despite low risk, potential negative reactions do need to be catered for'*.

Therapeutic effect

Overall the participants believe that aromatherapy is therapeutic, however, there was variation on the degree of therapeutic effects. With a wide range of views varying from

'is definitely therapeutic and should be treated as such' and *'is therapeutic as an adjunct to medical care, physical and psychological'* to *'cannot say it is a cure, not 100% convinced it is perhaps it is just the little extra caring touch'* it is *'primarily for relaxation and relief of signs and symptoms, make comfortable'* and *'believe it is therapeutic on the psychosocial level, enhanced environment, in touch with good memories, potential for more, but not enough evidence to use.'*

Scope of practice

The issue of the scope of practice was complex due to the diversity of use and users. Since *'aromatherapy is suitable for use by all in their home, nursing staff, aromatherapists and medical practitioners.'* The expressed view was that there was a *'need guidelines of scope of practice and liaison with other health care facilitators'* and that the *'scope of practice depends on training.'* The diversity of aromatherapy was seen as a positive thing. There was expressed concern over the lack of clarification of scope of practice.

Associations

Nurse participants criticised the International Federation of Aromatherapy as being too limiting: *'...can't do this and can't do that...'*; for *'...not acknowledging nurses prior knowledge;'* *'more aligned with beauty colleges'* and *'making it difficult for nurses to train in aromatherapy.'* Participants described this as *'a mistake'* and the development of a rival association was a good thing as *'now it is better that nurses can do short courses and integrate it into their practice.'* It was also pointed out that *'fighting between associations is a part of the professionalisation process, however they do need to get together and have an informed debate on acceptable practice'*. A final point commented on was *'No incentives to join the associations.'*

Area of Interest 3: Ideal future.

Ideal Future

The participants had a number of ideas for the future of aromatherapy in Australian health care the key aspects were: increased recognition of it's value and for it to be taken more seriously; for aromatherapy practice to be *'integrated into the health care system, treated the same as everything else'* such that it was an accepted part of the health care; being used to empower people by providing *'real choice in the health care system, providing greater respect for individual's choice in their health care'*; and even that ideally for doctors to train in aromatherapy and or aromatic medicine, as a branch of oral medicine. The gradual introduction was mentioned as a part of moving toward this ideal, as was increased training, more in line with other health care practices, thus providing increased credibility for practitioners. Research into aromatherapy was also part of the ideal future. It was

considered important for aromatherapy to be available for everyone and *'used sensibly and safely for self care'*

A final comment was that a participant *'would like to see cottage industry disappear because it has done a lot of damage'*(11/13). Prompting the feedback *'never thought of that but yes agree'* (AF) and *'but it has probably played a significant role in introducing aromatherapy to Australia.'* (AF)

Challenges

The challenges ahead for aromatherapy's forward movement in the Australian health care system focused around knowledge and awareness of aromatherapy: what it is, isn't, how it is seen, its knowledge base and how it is presented. The *'public attitude of why should I pay?'* (12/13) was also mentioned. The participants indicated that the lack of distinguishing between aromatherapy as a therapy and aromatherapy as a commercial venture was a problem for aromatherapy's forward movement. It seems that the diversity of aromatherapy played a role in this, with the nice smelling side promoted more than its therapeutic value. With the commercial industry running with this aspect with *'good marketing by fragrance industry'* (13/8)

Credibility was seen as an important obstacle for the development of aromatherapy in health care. Participants expressed a concern over: the way aromatherapy is presented with an *'over zealous attitude, resulting in a lack of critical thinking ...not acceptable to challenge anything that is said.'*(13/14); the education standards, lack of tailored education and *'credibility, research is part of this'* (7/6) the lack of good quality research provided further obstacles. It was expressed that there are *'many issues needing informed debate for it to move into the health care system'*(15/16).

Other Issues

TGA

The Therapeutic Goods Act was criticised by three participants, each in a specific way. These were: *'an apparent loop hole in TGA allowing poorer quality essential oils to be listed/registered'*. *'Hasn't got involved in public education...Hasn't really got its act together, info with product, first aid use and labelling, it is a waste of labour for every*

company to do all that is required.'(10/12). These comments also drew comments in the feedback including *'I agree,' '(apparent loop hole) not sure that is so, many do not seek listing/registering- costly,' '(hasn't got involved) actually has- a great deal'* and *'(waste of time) why? Manufacturing responsibility'*

Attitudes

Attitudes in health care looks at the perceived attitudes of nurses, doctors, aromatherapists and clients in the health care system. A couple of participants expressed disagreement with the idea that nurses are caring and doctors are not, *'I don't think it is true that doctors aren't caring'* (7/16). They felt it was the personal beliefs of the individual and or their training that made the difference in the care provided.

There were a couple of comments on the resistance within the health care system to the introduction of aromatherapy however the general idea was that as aromatherapy was *'something new, need to expect opposition.'*(3/10)

A frequently expressed consideration was the attitude of the health care recipients. The view was that there were two types of attitude of recipients: those with a dependence on the health care system who expect the 'fix it' mode of care. It was expressed that education may assist in moving them forward; the second attitude in which individuals were *'personally responsible for own health/lifestyle choice'* however this would require the

*'health care system (needs) to over come social dependence of
'someone else will fix it' such that people see their own potential
to maintain their own health reducing costs' yet
acknowledging that it
'can be hard for some people to take responsibility for their own
health...people have a lot invested in not being well... 'create
illnesses that met needs, not met in other ways'(8/10)*

Nurses' key words:

Diverse, integrative, undervalued

Nurses' key issues:

Knowledge, training, professionalism, choice in healthcare (as a reflection of respect), scope of practice, need for research basis

Nurses' deeper meaning:

Despite varying views on how to achieve it, it appeared that nurses were focusing on care for the patients. It seems they were looking for ways to promote empowerment and choice for users of the health care system. The interpretation was that their primary goal was to improve the service they provided, in the patient's best interest.

Summary

In this chapter the data from the nurse participants have been presented. Nurse participants defined 'aromatherapy' as 'the therapeutic use of essential oils, plant extracts, for health and well being, physically emotionally and spiritually, suitable for specific conditions or symptoms.' The skilled and controlled use was an important addition for one participant. This definition was qualified with emphasis on the diversity of aromatherapy practice.

Most nurse participants believed aromatherapy practice to be a profession and those that did not would like to see it become one, despite the view that it had some way to go to do so. They believed aromatherapy practice is undervalued and were keen to see aromatherapy practice developed and integrated into the Australian health care system. The data revealed four key ideas behind the drive: an understanding and appreciation of the value of caring and complementary therapies in health care; a move to increase the provision of an integrative health care service that provides a real choice to individuals receiving the service; the potential for aromatherapy to play a role in reducing the load on the currently over strained health care system by using aromatherapy as part of an educational process that empowers individuals to take more responsibility for their health; and their belief in aromatherapy practice.

A selection of these nurses further extended and refined this integration process by expressing concern about how this integration process is occurring. There was concern over unprofessional integration of aromatherapy practice into nursing practice; the quality and suitability of aromatherapy training including scope of practice; the state of aromatherapy knowledge noting a need for both research and critical thinking; concerned with safety and risk management; and the need for appropriate policy development. Overall the nurse participants were very keen to develop aromatherapy practice within the health care system with a focus on improving the care for the patients and ways to promote empowerment and choice for users of the Australian health care system.

Part Three

Discussion

To be healthy is far different from not being sick. Health means to feel good, strong, alert, rested, mentally sharp and physically active. Health means to look forward to challenge, both mental and physical. It means time passes quickly rather than dragging. Only you can assess your health. Doctors can tell you you have no observable illness, which is a far cry from health. To be healthy, you must have good control of your life

Glasser, 1984

Chapter 10

Comparison of Interview Results

Accepting a new idea can be as challenging as jumping off a cliff.

Allen, 2003

In the previous chapters the data from the interviews have been outlined. The purpose of providing this grounded data is for the development of a relevant critical theory on the professionalisation of aromatherapy practice. Thus this chapter will look at the difference between insights provided by the aromatherapists' and the nurses discussing them with regard to the issues of: what aromatherapy practice is presented to be; its perception as a profession; what a profession is understood to be and; what the participants would like for the future of aromatherapy. When considering the future of aromatherapy practice how participants see aromatherapy practice fitting into the Australian health care system and what if any obstacles they see for its development will be included.

I Aromatherapy Practice

Previously it was noted that the definition for aromatherapy is so broad as to be ineffective (Kusmirek, 2003). As a consequence it is of no value for a meaningful nomenclature for the practice of aromatherapy or its service. The broadness of the term is said to be due to the diversity of the practice (King, 1994) and its use. The lack of distinction of aromatherapy as a health care practice from aromatherapy as a commercial enterprise compounds the issue. In an attempt to clarify or at least gain insight into the apparent identity crisis and what service aromatherapy practice provides the issue of what aromatherapy practice 'is' is considered by definitions and methods of application utilised. As the practice is largely seen as holistic and there maybe some confusion as to what 'holistic' is, the idea of holism was also investigated.

Definition

Aromatherapist participants defined aromatherapy as the 'use of essential oils, plant extracts, for health and wellbeing, body mind and spirit.' Similarly the nurses defined aromatherapy as 'the therapeutic use of essential oil, plant extracts, for health and wellbeing, physically, emotionally and spiritually, suitable for specific conditions and symptoms'. The nurse participants added 'therapeutic' and 'specific conditions,' and one nurse participant added the 'skilled and controlled use.' The result was that the nurse's definition gained a specifically therapeutic designation. However both groups of participants 'qualified' the definition with additional information.

Both groups noted that aromatherapy is generally seen as ‘nice smelling stuff’. They also noted the diversity and different levels of practice or use of aromatherapy and expressed the view that it is unfortunate that aromatherapy practice appears to be associated to the commercialised and ‘nice’ aspects of aromatherapy rather than its ‘therapeutic’ qualities. Similarly, both groups expressed the view that most of the apparent growth of aromatherapy is related to the ‘nice smell’ and ‘beauty therapy’ nature of aromatherapy rather than its potential ‘therapeutic value’.

In their comments aromatherapists emphasised that aromatherapy is a ‘natural therapy’ and more than a ‘nice smell’. Aromatherapists also described aromatherapy in terms of its uses including as a tool for: health and wellbeing; stress management; and nurturing. These comments were extensive enough to give rise to emerged categories labelled ‘levels’ ‘uses’ and ‘public perception’. Alternatively despite their noted similarity, nurse participants tend to focus their attention on therapeutic, health care practice considerations. The result was the emergence of categories on the ‘essential oils’ and the ‘process of introducing’ aromatherapy into nursing practice.¹¹ These categories will be discussed further following application methods and holism.

Overall despite the greater clarity of therapeutic nature by the nurses, there was an apparent united view on what aromatherapy was as observed by the similarity of the definition of aromatherapy. These definitions corresponded well with the literature definition where aromatherapy was defined as ‘the skilled and controlled use of aromatic plant extracts, essential oils, for the purpose of health and wellbeing’ indicating a united and agreed practice. However, when the application methods were considered a very different picture was observed.

Application methods

Responses to the application methods used in aromatherapy practice were inconsistent and controversial within and between both the aromatherapist and nurse groups. The only aspect agreed upon by all was that there were a variety of application methods. The data highlight the diversity of what aromatherapy practice is considered to be related to the appropriate ‘use’ of the essential oils. Controversy was the dominant theme for these data.

¹¹ Whilst the issue of introduction first came up in this section of the interview it will be discussed in area three- aromatherapy in health care due to the overlap of relevance.

The proposed 'identity crisis' resulting from confusion and lack of clarity of what aromatherapy practice 'is', noted in Chapter Three, seems to be related to how the essential oils are 'used' and their 'effectiveness' rather than that they are 'used'.

Aromatherapists as a group viewed the topical use, specifically massage, of the essential oils as the primary method of application. The tendency to lean toward massage aromatherapy and the non oral use of essential oils is indicative of the dominance of the original safer Maury (1989) style of aromatherapy in Australian aromatherapy practice. However this unity was undermined by inconsistent views on the appropriate dilution and effectiveness of the essential oils. This was especially the case for the appropriateness of direct (undiluted topical) application of essential oils. On the other hand many nurses expressed the view that focusing on massage was restricting and that any method of application is fine if the user is appropriately trained. Nurse participants embraced a greater diversity of application methods than the aromatherapists.

The issue of the oral use of essential oils in aromatherapy was a point of contention. That oral use was against IFA policy was significant for a number of aromatherapist participants. Despite the strong support for anti-oral use of essential oils in their practice (many did use essential oils orally for themselves) there was one aromatherapist who used oral administration as their primary method of application in their practice, representing the medical use of aromatherapy in Australia. Most nurses were supportive of oral use of essential oils, if the practitioner was appropriately trained.

Nurses took a diverse approach consistent with the views of Roebuck (1988) and Tisserand and Blancs (1995). They did however emphasize a need for the use of the essential oils to be in accordance with appropriate training. It was suggested that doctors were most suitable practitioner for the oral use of essential oils. Again this is inline with Maury's (1989) original view. Within the nurse participant group a significant divergence from the 'any application if appropriately trained' was a lone nurse's view that it is necessary to be cautious and to not use either oral or direct application in nursing.

This nurse held strongly to this cautious approach stating that there is inadequate evidence for these methods of application. In the feedback from nurse participants in response to collated nurse data this stance was questioned by the other nurse participants, with

comments asserting that there is supporting evidence as noted in Chapter Three. However it was also noted that this cautious approach increases the chance of acceptance into the health care system, with the potential to develop once accepted. This approach amounted to a strategic approach to the integration of aromatherapy (and other CAM) into the health care system.

The data provided by the participants supported the view that the issue of application methods is indeed an area of controversy and contention, with a number of different approaches to using essential oils in health care reflecting different views on:

- 1) Safety of essential oils- aromatherapists (on the whole) tending to lean toward caution and restriction as a means to deal with safety issues. While nurses tended to focus on the need for appropriate training to deal with safety, including the lone nurse against oral and direct use.
- 2) Effectiveness- all participants agreed that the essential oils were effective. However there were different ideas on the appropriate dose. This could be related to two theories of how the 'effect' of the essential oils is induced. The biological approach stipulates effect related to dose. While for the energetic holistic approach the effect is due to the presences and matching of energy frequency, thus is not amount dependent. As a consequence 'how much' and 'how' the essential oils are 'used' is an issue.

These two debates appear to be central to the issue of clarification of what aromatherapy practice is.

How to deal most effectively with safety issue means considering if training in appropriate use is enough or ought restrictions to essential oil and their use be endorsed. However it is also noted that aromatherapy is seen as a low risk practice by both groups of participants and is promoted as a low risk (Worwood, 1990; Hopkins, 1991) or relatively safe (Cooksley, 1996) modality. Though some participants did express some concerns over the use of essential oils in pregnancy, of skin irritations, along with the oral use of essential oils. This view is reflected in literature and is countered with the view that by providing education essential oils are both effective and safe (Price & Price, 1999). However the two

opposing views by participants were strongly held, with strong comments against opposition views in the feedback to the data. As the researcher I suggest that a lack of distinction between aromatherapy practice and home use of essential oils may be adding to the issue.

The second point on the effectiveness of the essential oils (thus aromatherapy practice) is seen as a reflection of a debate based in the different view on how the agent has its therapeutic effect. As noted in the literature there is both consideration of the different dose in different styles of aromatherapy practice and questioning of effectiveness of low dose and massage applications (Lis-Balchin, 1997) possibly indicating a lean to the biological approach where effect is 'dose dependent'. From this stance achieving clarity of the mode of effect of essential oils will assist greatly.

While this data is being looked at in relation to an identity crisis, one participant noted (in the feedback comments) that this diversity differentiates practitioners (thus the service provided) and gives choice to potential clients enabling them to select the practitioner that works the way they want. This view enables this diversity to be seen as a value and co-relates to the view that individual professionals explore and clearly declare their values (Reece, 2003b)¹². Whether this diversity is seen as part of an 'identity crisis' or the empowerment of 'choice' the diversity indicates at least some of the reasons why aromatherapy practice experiences challenges in its promotion as a health care practice. It is not necessarily the diversity rather the lack of clear articulation of the diversity and more specifically what aromatherapy practice 'is' that is an issue.

This lack of clarity may very well play a role in the variation of views on what is acceptable aromatherapy practice or be a reflection of the debate in literature on what is appropriate. With early moves to distinguish between different approaches to aromatherapy practice (Tisserand 1993b; Pénoël, 1999) one has to ask why these efforts have not been successful. Is it inactivity on the behalf of aromatherapists as suggested by Harris (2002)? To gain clarity the question that needs to be asked and dealt with is could this diversity be integrated into a working definition? Or ought it to be standardised out? The debate raises valid and valuable issues for aromatherapy practice, particularly if it wishes to be taken

¹² Pg 77

seriously as a health care modality. Regardless presently the unity on the broad definition of aromatherapy gives an illusion of unity when in practice there is no agreed definition of what the practice of aromatherapy 'is' nor its scope of practice. Reinforcing the literature comments that the term 'aromatherapy' is so broad as to be of little value.

Holistic

Another important aspect of aromatherapy practice is its framework which is said to be holistic. Due to the previously noted apparent confusion as to what holistic practice 'is' ¹³ insights were gathered into the possibility that this confusion is also an issue for aromatherapy practitioners. This is an important consideration for clarity of the philosophical underpinning of the practice and thus clarification of the practice.

The views expressed by both the nurses and aromatherapists focused on the multi dimensional quality of 'holism'. Aromatherapists primarily spoke in terms of the body and mind, while nurses added extra dimensions (environment and spiritual). There were comments on the vagueness of the term 'holistic' itself, indicating an awareness of the lack of clarity of what the term is referring to. Indeed 'holistic' is not simply a matter of being multi dimensional¹⁴ and neither group made the distinction. Thus it appears both groups primarily understand holism to be the 'body mind' and if this is so they could be describing the analytic 'body mind', rather than holism. This may be an indication of confusion between the two approaches to health care or a reflection on Evans' (1996) comment on the difficulty in distinguishing the two approaches¹⁵.

Alternatively it may be part of an attempt to down play the spiritual quality of the practice in an attempt to be accepted. This possibility is indicated by comments on the vagueness of spirituality (by nurses) and the need to be careful of using terminology such as spirituality (by aromatherapists). This could be a reflection of an attempt to speak in biomedical terms (by aromatherapists) for recognition and an acknowledgement of a lack of clear articulation of the terms meaning. If this is the case issues of practice integrity as expressed by Grant (2003a) are being raised.

¹³ Chapter 1 for discussion, Table 1 for distinction.

¹⁴ Page 14

¹⁵ Page 15

It would be inappropriate to neglect that some participants referred to connectedness and others mentioned the need to listen to and adjust to the client, these do indicate some of the qualities of holism. The need to listen was spoken of under the practice of aromatherapy by aromatherapists' rather than under thoughts on holistic practice, highlighting different aspects of holistic practice without clear understanding of them. The same can be said of the use of natural products in the practice. The issue of holism and its different aspects is important and will be discussed in a later chapter.

Aromatherapist and nurse emerged categories

The act of 'qualifying' the definition of aromatherapy with additional information resulting in the emergence of categories beyond the definition was taken to indicate an awareness that the 'definition' of aromatherapy fails to adequately define aromatherapy practice. Indeed some aromatherapists commented on the issue and raised questions of renaming the practice. Aromatherapist emerged categories extended the definition noting the different levels of aromatherapy practice, the different uses of the practice, the practice itself and public perception of the practice. There was an expressed view that it was important to distinguish between the different levels and uses. 'Uses' referred to what aromatherapy could be used for including as a tool for health and wellbeing, for nurturing and for beauty therapy. The different 'levels' related to the amount and type of training of the 'user'.

The first category that emerged from aromatherapist data as the 'practice' tended to emphasise the value of practitioners over books, distinguishing lay and practitioner aromatherapy, advocating the benefits of attending a practitioner rather than following self help. The value of knowledge and experience as a source of practitioner knowledge were highlighted. The value of communication within the practice and the importance of the client reflection and self determination were also noted.

The final aromatherapist emerged category 'public perception' expressed the view that aromatherapy is seen as a 'nice smelly, beauty therapy thing' undermining the therapeutic nature of the practice. Whilst this point was also made by nurse participants it was emphasised more by the aromatherapists. Aromatherapists further extended the category with the addition of themes that aromatherapy is perceived as dangerous if pregnant creating the dichotomy 'no significant effect and yet potentially dangerous'.

The two categories that emerged from the nurses' data were 'essential oils' and the 'introduction process'. Both categories related to the 'quality of use' of aromatherapy in nursing practice. The essential oils category was highlighting a need for quality essential oils distinguishing that 'nice smells' could be used for relaxation, but essential oils are more than that. Some nurse participants expressed the view that an appropriate policy for use under the guidelines of 'quality use of medicines' was required due to the therapeutic nature of the essential oils. Others thought this view extreme and there was a need to be careful not to get carried away and scare people. Nurse participants also noted they felt it was important for essential oils to remain available for all. This difference in views is a reflection on the issue of how to deal with the essential oils. As 'therapeutic agents' should essential oils be restricted medications or freely available tools? The 'introduction process' as previously mentioned will be discussed further in the third area 'the future'.

II Aromatherapy As A Profession

As for the question of aromatherapy being a profession within each participant group there were some participants who questioned the view that aromatherapy was a profession. Of the aromatherapists one participant suggested that once aromatherapy was accepted in hospitals they would consider it a profession and a couple of others thought the number of aromatherapist practitioners was too low to be a profession. Similarly two nurses asserted aromatherapy was not a profession and in their view aromatherapy practice has a long way to go to become a profession. They saw nursing as a very good arena to take aromatherapy forward, noting the need for people to drive the professionalisation process and for mentors.

Despite these views the majority of both aromatherapist and nurse participants believed aromatherapy was a profession. Supporting the proposition that aromatherapists perceived aromatherapy as a profession and going against the proposition that nurses were less likely to view aromatherapy as a profession, despite the fact that the professionalisation of the nursing occupation has been an issue for nurses for some time. It is noted that generally nurses were unaware of the distinction between professions and occupations, indeed one nurse commented that they were not aware that there was a difference between an occupation and a profession. As there was such strong conviction by many that

aromatherapy was a profession it was important to consider just what a profession was understood to be by the participants.

What a profession was understood to be

The predominant view in both groups of participants was that aromatherapy was a profession due to the perceived skilled knowledge of the practice and that it was practiced as a means to provide an income. Some aromatherapists noted the need for ethics, standards, knowledge and a professional association. While a couple of nurses indicated an awareness of the need for a professional association, accountability, high level of skill and training as well as standards. There was also the view that a profession was something one did for the service or for the love of the practice, rather than for money. Both of these views lean to characteristics of a profession both current and historically, as outlined in Chapter Four.

The indication of the current view of what a profession is considered to be is seen in the expressed awareness of the need to meet certain criteria such as standards and having a code of ethics. The understanding of a profession as what one did for love of the practice or for the service, in preference to earning an income, can be related to the historical perception of a profession. For historically young noblemen not needing to earn an income practiced a profession as a service to the people (Elliot, 1972). However these views fail to meet today's criteria of a profession nor does it acknowledge the issues of being a profession today with the need to balance providing the 'service' with a need to 'earn' an income to ensure economic viability.

As a final point it is worth noting that those participants who did not see aromatherapy as a profession would like to see it as one and aromatherapists commented that it was important for aromatherapy practice to be seen as a profession as they believed it acknowledges the value of the practice. These points are seen as a reflection of the esteem participants held for the practice of aromatherapy, the social status given to 'professions' and confusion regarding the difference between being professionals and members of a profession.

III Aromatherapy In The Future

Participating aromatherapists indicated that they felt it was important for aromatherapy to be seen as a profession for recognition of its value in health care. Indeed both participant groups expressed a desire for aromatherapy practice to have greater recognition for its value (with nurses specifying the therapeutic value) and for the use of aromatherapy as a health care modality within the health care system. Both groups expressed the view that the ideal future was for aromatherapy practice to be an accepted health care modality such that it was successfully integrated into the Australian health care system. Other aspects of an ideal future for aromatherapy practice mentioned were: increased awareness and use of the multiple levels of aromatherapy practice with clear distinctions between each level; clear guidelines of practice; increased standards; a central body and better informed/educated public. The current progress of accrediting aromatherapy training starts the process of increased standards and possibly the distinction between levels of practice.

Nurse participants expressed a strong lean to the idea of aromatherapy as an integrative part of the dominant health care system acknowledging that it maybe because they are within the dominant system. However this integrative view was prominent in both groups. Nurses felt there is a world of potential for aromatherapy's development in health care. While aromatherapists would like to see aromatherapy within the system used by aromatherapists and other health care workers alike. Aromatherapists mentioned that it was very important that the principles of aromatherapy practice were not lost in the integration process.

Overall the two groups were united in the view for the future of aromatherapy practice to be within health care. Both groups were keen to see the multilevel use of aromatherapy including self care and use by a variety of practitioners. There was one significant difference nurses included the use of oral/medical aromatherapy by trained medical doctors, while aromatherapists primarily avoided the use of oral application. This is not necessarily to say they would not support the idea if it was discussed with them, rather from the provided information they were not supportive of oral use in aromatherapy practice as it is today. That internal use of essential oils is part of the proposed advanced diploma (CSHISC, 2006) in aromatherapy indicates this openness.

Aromatherapy's perceived value in the Australian health care system.

Despite some difference in wording both participant groups were united with regards to key perceived values aromatherapy practice could contribute as a health care modality. These key values were complementary, increased caring, respect, choice, prevention and personal responsibility. Aromatherapists and some nurses also mentioned they felt the essential oils may, in some cases, provide a safer option than pharmacological medicines and that the use of aromatherapy could reduce the cost of and pressure on the health care system. Nurses further mention increased effectiveness, increased family involvement, positive public relations and staff care.

Primarily aromatherapy was seen as a complement to biomedical health care to enhance the service to clients. Aromatherapy practice was seen as a means to promote and enhance positive, empowering health care practices. With aromatherapists suggesting that aromatherapy practice has the ability to deal with things biomedicine does not such as dealing with emotional aspects; personal growth; empowerment; increased ability for preventative and self health care. One nurse suggested that it opens the question of what is medicine.

As part of the complement to biomedicine aromatherapy practice was seen as a preventative health care facilitator, such as for health maintenance; stress management; the promotion of wellness and caring. Both aromatherapists and nurses indicated they believed aromatherapy practice enable a means of moving away from a purely physical approach to health care by increasing the caring quality in health care.

Choice and empowerment were seen as a significant contribution of aromatherapy. Aromatherapists talked of aromatherapy practice as an option in the system. Nurses felt aromatherapy practice was important for the bigger picture of increasing choice in the health care setting expressing the view that aromatherapy practice would enable empowerment of choice and increased personal responsibility. Both groups saw the provision of choice in the health care system as important as it provides respect for an individual's personal health care practices and beliefs. This is in line with Seedhouse's (1986) comments on the requirement to respect individual beliefs and priorities in health care rather than imposing ones own.

Nurse participants clearly articulated reasons for the integration process, the reasons were described as: an understanding and appreciation of the value of caring and complementary therapies (in general) in health care; a move to increase the provision of an integrative health care service that provides a real choice to individuals receiving the service; the potential for aromatherapy to play a role in reducing the load on the currently over strained health care system, by using aromatherapy practice as part of an educational process that empowers individuals to take more responsibility for their health; and their belief in aromatherapy practice.

Introduction process as part of future development

As for the process of integration itself, the nurses expressed two distinct views. The first dominant view was a 'go for it' approach expressed by those very keen to begin the integration process with each doing so in their own way. The second view was a cautious approach emphasising the view that it is appropriate to go slow and integrate carefully to enhance the possibility of a smooth successful integration. The view was that there was a need for a gradual process of introduction to avoid incidents and to work within the system recognising the dominant paradigm, that not all embraced the idea and that resistance is to be expected as part of change.

For the nurse participants appropriate training, scope of practice, the state of aromatherapy knowledge, professionalism, unprofessional integration, safety, risk management, the need for appropriate policy development and the idea of choice in health care were noted as the primary concerns for the development of aromatherapy. All indicators of a professional approach to the integration process, similar to topics of debate in nursing journals around the need for professional accountability and the recognition for a need for different training programs for nurse and aromatherapist due to different approaches to aromatherapy use (Mackereth, 1995; Avis, 1999).

IV Challenges for Aromatherapy

Challenges to the development of aromatherapy were seen quite differently between the two groups. However both participant groups agreed that the lack of clarity of what aromatherapy was and was not was an important issue. Participants talked in terms of the

'lack of distinction' between the different levels of aromatherapy as well as the therapeutic practice and the commercial venture. Both groups also saw issues around the essential oils themselves.

While both aromatherapists and nurses expressed issues regarding the quality of essential oils as an obstacle, aromatherapists emphasised it more. The availability of synthetic oils, no need for the essential oils to be registered, no distinction between qualities of essential oils and the cost of good quality essential oils were all raised as issues that created obstacles for the development of aromatherapy practice.

As a group aromatherapists expressed the view that they felt the government was holding aromatherapy's growth back in particular, but not exclusively, related to bureaucratic procedures and the government's economic focus. Along with the government, dealing with the dominance of medical practitioners and obtaining recognition from the medical profession was seen as an obstacle by some, as was the pharmaceutical industry dominance for economic purposes. Some aromatherapists did however acknowledge that they themselves were an issue in relation to their lack of unity and apathy and the lack of funds to promote the practice.

Alternatively nurses focused on the credibility of aromatherapy practice expressing the view that the practice is undermined by how aromatherapy is presented, both as a 'nice smell' and by over enthusiastic aromatherapists. Over enthusiastic aromatherapists were, at times, seen to present aromatherapy as something 'wacky' and as lacking 'critical thinking,' as a consequence they undermined the credibility of aromatherapy practice. Nurses also felt poor education standards, the lack of tailored education and quality research undermined the potential development of the practice.

Both groups acknowledged that there was a need to address issues related to the knowledge base of aromatherapy practice (this important issue will be expanded on in the next chapter under professionalisation as a traditional profession). Both groups spoke of the need for improvement of the knowledge base due to issues of misinformation and reliability of the current knowledge base. Similarly the need for research was mentioned by both groups however aromatherapists also expressed a concern about the appropriateness of scientific research for aromatherapy as well as issues around funding such research.

Aromatherapist training was seen an issue for aromatherapy practice's development, related to the need for appropriate quality training as mention by nurses. Both groups felt there was a need for training to be tailored to the particular course requirements related to the level of aromatherapy practice and its intended use, nurses emphasised the point more.

V Key Difference

By considering the key issues and deeper meaning we can see that the nurses tended to be more concerned about the professional development of aromatherapy into their health care practice in the best interest of the patients, in order to improve the service they provided. Whilst the aromatherapy practitioners where more concerned with their survival as aromatherapy practitioners. This is a natural stance to take for whilst both groups were keen to see aromatherapy accepted and recognised within the health care system, the nurses have a secure career and income whilst aromatherapy practitioners may not be experiencing the same degree of security. Nursing is an accepted and recognised field whilst aromatherapy practice is expressing a desire in obtaining acceptance and recognition.

Nurses came across as more confident on the integration process and their role in the process. The significant difference between the groups was observed in the driving force for the development of aromatherapy. Nurses were driven by a desire to enhance the service they provided. Despite varying views on how to achieve integration it was apparent that nurses were looking for ways to promote empowerment and choice for users of the health care system. Their primary goal being to improve the service they provided in the patient's best interest. Thus they had a focus on care for the patients, whether this be primarily around providing quality care or reflective of an aspect of empowerment giving greater choice and ability (self care) to the individuals. The over all view reflected a desire to work with the system, yet the need to emphasizes the humane and caring qualities of healing.

Alternatively the underlying theme for aromatherapists, in regards to the integration process, appears to be a concern for survival. Indeed in the interview some aromatherapists expressed concerns related to earning potential, noting a need to be multimodal to improve

earnings and concern of being regulated out of business. There was a strong sense of aromatherapists still establishing job security. There was also an expressed concern of losing the 'essence' of aromatherapy as a distinct and valuable health care modality, if the occupation does what it is being asked to do (specifically research) in order to fit in to the health care system. There was a sense of a 'damn if we do and damn if we don't' in regards to doing what they believed they need to do for integration and recognition in the health care system. This concern may be an influencing factor for producing the observed fear of misrepresentation and suspicion in the recruiting of aromatherapist participants.

Aromatherapists whilst driven by their love of the service and commitment to the essence of the service, just like the nurses, their overriding drive appeared to be due to the need to provide economic security a core issue for all members of our society.

Summary

In this chapter insight from participants supports the idea that despite having a clear and concise definition aromatherapy practice is a broad and diverse field which lacks unity on what the practice of aromatherapy is, supporting the idea that aromatherapy as a practice has an 'identity crisis'. For while aromatherapy practice is seen as the 'use of essential oils for health and wellbeing' just 'how' the essential oils are used for that purpose is debated. Further the practice of aromatherapy lacks unity and clarity on two core issues, 'safety' and 'effectiveness' of the practice. Other key issues for aromatherapy practice noted by both aromatherapists and nurses included a lack of 'distinction' from other non health care aspects of aromatherapy such as the 'nice smell' and 'beauty therapy' aspects, plus the commercialisation of aromatherapy products; and between the different uses and levels of aromatherapy practice in health care. Finally there is a lack of clarity around what is 'holistic' despite it being claimed as a core principle of practice. This issue effectively undermines the recognition and acceptance of therapeutic qualities of aromatherapy practice and thus the recognition of its perceived potential value in health care.

Aromatherapy is primarily perceived to be a profession despite not meeting the criteria, according to literature describing professions. It was clear that both groups of participants wanted and saw value in the integration of aromatherapy practice into the health care system, primarily as a complementary practice. They believed it was important for the

provision of key values including increased caring health care service, respect, empowering choice, promoting preventative health care and personal responsibility. Whilst nurses were primarily concerned about the process of integration aromatherapists were also concerned for the need to establish a means of income. A reflection of the core issue for all of establishing economic viability and maintaining integrity with the service provided. Issues for the development of aromatherapy practice in health care included the lack of clarity of what the practice is, quality essential oils, bureaucratic procedures, dominance of the medical profession and pharmaceutical companies and funding.

Whilst there was much in common between the two participant groups regarding the development of aromatherapy practice in health care and the value of this, the drive for the development was found to be different. Nurses appeared to be primarily concerned with enhancing the service they already provide and how to go about doing this. Aromatherapists' on the other hand were influenced by the need to establish economic viability. As the development or professionalisation of aromatherapy practice does appear to be wanted by both groups the next chapter will consider this process within the critical theory framework.

Chapter 11

Potential Pathways for the Development of Aromatherapy Practice

If the work is too skilled for amateurs, the status of the profession tends to rise. We respect those whose knowledge and skill seems to be right out of our range. Thus would-be professionals can foster regard either by delivering the services that are too complex or technical for clients to understand or emulate, or by appearing to do so, through diligent and regular use of incomprehensible rituals and jargon. Howard, 1998

Sometimes of course we must tolerate what we ourselves have not taken on. We must tolerate what has been forced on us by what are often called, passively, neutrally, 'historical' or 'social' circumstances. Dowrick, 1997

From the literature and interview data in the previous chapter it has been established that the development of aromatherapy practice in the Australian health care system is an issue of interest. Aromatherapists and at least some nurses believed that it would be valuable to integrate aromatherapy practice into the Australian health care system. This is due to the perceived potential valuable contributions that aromatherapy practice could make if it was successfully in gaining such recognition. This chapter is to focus on the potential pathways for the development of aromatherapy in Australian health care, which fundamentally may be applicable for other CAM modalities.

Consequently this chapter will first consider the context for the professionalisation including why the occupation wants to professionalise, the false consciousness and the related social crisis. The chapter will then outline what the practice of aromatherapy would need to do to fulfil the criteria of a profession and the other pathways explored. As part of this process the impact of other health care professions and the Australian government policy on aromatherapy practice's development will be considered. Other issues that influence the discussion included consideration of job security for aromatherapists and the felt dissatisfaction of aromatherapist. As part of the consideration of the choices effectively available for aromatherapy's practices development the most likely pathway in Australian health care will be suggested.

I Context For Professionalisation Of Aromatherapy

The literature informs us that the main reasons for professionalising include: to gain recognition, to create a market for the service, to maintain and increases social status and to obtain monopolised power (Hughs, 1958; Carillo & Zazzaro, 2001). Collins (1990) sees professionalisation as a struggle for power, with the dynamics of power and its shadow victim hood seen to play an important role in the process (Hall, 1993; House, 1995). This prompts the question 'is it fear that drives the professionalisation of some occupations?'

Alternatively Morrell (1990) describes professionalisation as a market driven natural sorting of good and poor providers. Yet another reason for some occupations to professionalise is to develop standards of intellectual rigour, integrity, or better systems of training or regulation, not necessarily aiming to become a profession. Importantly it has

also been noted that an occupation may be at risk of losing integrity with their underpinning principles of practice when professionalising. Consequently House (1995) warns of the need to be careful of a 'lemming like approach' to professionalisation.

There is no indication of a market driven professionalisation for aromatherapy practice in Australia. Literature and interview data indicated that there is a lack of recognition for the therapeutic value for aromatherapy practice. As a consequence there is currently an inadequate market for therapeutic aromatherapy practice to support a market driven professionalisation. However there is evidence that the development of CAM is market driven and thus a consideration in the overall development of the Australian health care system. As a consequence of this market demand there is also a drive to ensure 'good' service is provided by CAM practitioners by the dominant health care profession, biomedicine, and the Government. This drive does have consequences for aromatherapy practice's professionalisation.

The interview data indicate that aromatherapists and nurses want the practice of aromatherapy to be recognised for its therapeutic value. Whilst gaining recognition for the value of aromatherapy was a key issue for both interviewed groups, recognition and securing an income were primary reasons for professionalisation by aromatherapists. This suggests that creating a market for their service is a reason for aromatherapy practice's efforts at professionalising. However professionalisation for the status of being a profession, as a means of social mobilisation, is not clearly indicated. Social mobilisation may be part of the drive for some, in the sense of increased financial income and the related status in our culture that is obtained by this. At the same time for others this is not necessarily the case as participant's insights show that some aromatherapy practitioners step back, making a 'life style choice' to practice what they believe allows them to make a valuable contribution. Recognition to secure an income (economic viability) by creating a market by aromatherapists is more strongly indicated than recognition for social status, though these two issues are generally entwined.

There is no indication that monopolisation and control of the occupation's knowledge and practice is a driving force for the development of aromatherapy practice by participants in this study. Rather aromatherapists indicate the opposite when they expressed the view of seeing aromatherapists and other health care workers alike, using aromatherapy in health

care practice. The view that it is important that aromatherapy be used as a self care modality further reinforces a lack of drive for monopolisation. This is contrary to the process of monopolisation being indicated in the development of aromatherapy as part of the process of restricted training, Government accredited training and practitioner registration which may be driven by a few driving members of the practice association(s). It is possible that the main focus of the process of restriction and Government accreditation maybe for standardisation. This is possibly influenced by the desire to create a market by gaining recognition for the service.

Insights also show that a fear of being regulated out of a job, a sense of powerlessness (power of medical, pharmaceutical, commercial and a need to fit in) by aromatherapists is part of the drive for recognition. Recognition is wanted for both the practice of aromatherapy and for the practitioners of aromatherapy, the aromatherapists themselves. As a driving force the risk of losing the 'essence' of aromatherapy practice acts as a countercheck to the process of professionalisation related to the underpinning principles of aromatherapy practice and paradigms of health care. The awareness of a mismatch of principles is very important and begs the question of, how much of the aromatherapist drive for professionalisation is fear driven and appropriate?

Finally aromatherapy associations are travelling down the path of gaining accreditation via the Government's system of national vocational education and training. This system of vocational education and training is a way of providing Government accredited courses which maybe perceived as a means to provide a sense of recognition for the occupation by *de facto*¹⁶. How effective this *de facto* recognition would be in gaining employment and clients needs to be considered. For Government recognition of the training does not necessary establish the needed reconnection by employers and potential clients. Desire for recognition and fear appear to be the primary driving forces for the professionalisation of aromatherapy practice. Indeed it is aromatherapy associations not the government, nor the public that drive the process.

¹⁶ Page 56

Theory of false consciousness

The interview data found that both aromatherapists and nurses predominately perceived aromatherapy to be a profession. These findings are in line with the interpretation of the literature indicating that there is a belief that aromatherapy is a profession despite not meeting the criteria of a profession. According to the outlined criteria the belief that aromatherapy practice is a profession indicates a false consciousness.

The belief that aromatherapy is a ‘profession’ may have developed from the common misperception that a ‘professional’ is a member of a profession when it does not denote membership of a profession¹⁷. This mistake is quite understandable, as the different meanings of ‘professional’ are not distinguished clearly in the general public. An alternative reason for the misperception of aromatherapy as a profession is related to the existence of professional associations.

As previously mentioned the existence of a ‘professional association’ has been used to support the idea that an occupation is a ‘profession’. This possibility is reinforced by the observation that CAM occupations (not necessarily aromatherapy specifically) relate their professional status to the existence of professional associations¹⁸. The use of self developed and or taxation department definitions for a professional association confuses the issue of what a professional association is especially related to a ‘profession’¹⁹. As Johnson (1972) noted ‘the mere existence of an association is not in itself an indication of professionalism’. This misunderstanding may be further reinforced if the traditional view that a profession is an occupation done for the service or love of the occupation over and above earning an income is held. The La Trobe Report (2006) further confounds the issue by referring to CAM occupations as professions, when it also found them to have inadequate standardised training (not all at tertiary level)²⁰.

It is important to distinguish between a ‘professional’ as a member of a ‘profession’ and a ‘professional’ as someone who does something as a means to earn an income and or someone who does a job well. Similarly between a professional association that represents

¹⁷ Consider comments in chapter 3 on professions and professionals

¹⁸ Page 37

¹⁹ Page 37

²⁰ These occupations are clearly in the process of professionalisation however that they ‘are’ professions can be debated.

an occupation and a professional association that represents a profession. Using the term professional to mean service above an amateur may well be fitting for the practitioners of aromatherapy practice. Further to use the term 'professional association' as a body representing aromatherapy practitioners is also fitting. However to take these terms to infer that aromatherapy practice is a profession is an inaccurate use of the terms. The stance can be taken as an attempt at aggrandising the occupation in the hope of gaining the desired recognition, which in turn provides opposing professions and occupations grounds to discredit aromatherapy practice.

Whilst the belief that aromatherapy practice is a profession is an understandable misperception it is not a realistic view of aromatherapy practice's occupational status and maintaining this stance is detrimental to the professionalisation of aromatherapy practice. This misunderstanding is reinforced by the continued referral to the practice as a profession. This illusionary belief has not served the occupation, but rather has increased frustration and felt dissatisfaction. An alternative view is to accept that aromatherapy practice does not meet the criteria of a profession as defined by both the literature on professions and in the market place. By recognising where aromatherapy practice stands within the established system, it increases the ability of the occupation's associations and members to make appropriate choices so the occupation may move in the direction wanted for its development.

Theory of social crisis

According to Fay (1987) a social crisis can be defined as when a dominant group is challenged by a sub group such that the dominant group is forced to make adjustment to maintain their dominant position in society in order to avoid losing the dominant status. The social crisis noted in this study was outlined in Chapter One as being within the health care system. This crisis is due to the demand by the public for CAM health care, they do so out of an expressed dissatisfaction with biomedical health care, the dominant health care providers, and a desire for a better quality of life. In response to the demands biomedical practitioners initially criticised CAM and have now been forced to accept that CAM is to become part of the health care system due to the continuous increasing public demand, yet resistance continues. CAM practices are now expected to meet the standards set by biomedicine in order to be accepted in health care.

This social crisis came about as part of the process of professionalisation of biomedical practice. In its professionalisation biomedical practitioners have historically established dominance and marginalised other health care practices. However the biomedical profession has failed to provide the ‘magic bullet’ they promised and are beginning to lose the dominant and authoritative status that they had. People are now looking for more responsibility and choice in health care, as part of this process CAM practices are in demand²¹.

The driving force for this change is led by the public due to their felt dissatisfaction with biomedical health care. If the biomedical health care system does not respond to this demand they may be at risk of losing dominance as the public increasingly turn to CAM. It is apparent that biomedical practitioners as individuals and as an occupation have recognised the issue and are responding to it. The observed response is to integrate CAM into the health care system. Despite the primacy of this social crisis and its felt dissatisfaction it is not the intended focus for this study.

Focus felt dissatisfaction

The focus felt dissatisfaction of this study was one experienced within the context of this health care crisis, one that is not currently being responded to such that the felt dissatisfaction has any potential to be resolved. The felt dissatisfaction referred to is that of CAM practitioners wishing to be recognised as a health care modality, specifically aromatherapists. The felt dissatisfaction is argued to be based on the misperception or false consciousness that aromatherapy practice is a profession.

The belief that aromatherapy practice is a profession when it is not creates frustration for aromatherapy practitioners. For if aromatherapists believe themselves to be members of a profession with the same status as established professions they may perceive themselves as having equal footing as other health care professionals, including doctors, and expect the same trust and respect that is granted to these practitioners. The practice does not meet the criteria of a profession, nor do its members receive this level of recognition or trust from either related health care professionals or the public.

²¹ As discussed in chapter 1

Lack of Recognition

This lack of recognition for aromatherapy as a profession is also tied into a lack of recognition of the practice as a therapeutic one. This is believed to be due to a lack of distinction between aromatherapy as a therapeutic practice and aromatherapy as a commercial pleasurable venture. This situation has developed historically due to aromatherapy practice's principle development being in the beauty therapy field, as a self help modality and the commercialisation of aromatherapy. The failure to clearly and publicly distinguish aromatherapy practice as a health care modality, from other aromatherapy ventures, is likely to have played a role in reinforcing this situation. It is also suggested that this situation is worsened by a lack of unity within the practice related to the diversity of the practice.

On the matter of gaining recognition it is important to distinguish between aromatherapy as a therapeutic practice and the practitioners, for even if the use of aromatherapy is recognised in health care this does not automatically mean there is recognition for aromatherapists. This is reflected in interview comments by aromatherapist of concern of being regulated out of work. If aromatherapists are hoping that obtaining course accreditation by the Government will increase the level of recognition, this is questionable as recognition is primarily based on a valued service by experts. However, recognition maybe reinforced or enhanced when supported by an established profession.

True to essence of practice

A second reason for aromatherapists felt dissatisfaction is noted as an apparent double bind created by the desire to gain recognition and to remain true to principles of aromatherapy practice. The demands to fulfil biomedical standards using scientific research to gain recognition are perceived to be a betrayal of principles of holistic practice which aromatherapy is said to be based in. This is a reflection on the debate on the benefits of recognition and acceptance versus the loss of core principles of practice, in this case indicated to be due to the understanding that research is of an analytic nature and not suitable for holistic practices. Indeed the structure of the cultural/social system supports an analytic approach to knowledge development based in modern science rather than a holistic approach.

This understanding of incompatible research methodology is suggested to be the result of a lack of knowledge of and distinction between the modern and post modern approaches to research and clarity of the principles of practice. This in turn, is due to the dominance of the modern science and hierarchical paradigm in society. The inability to clearly recognise and articulate the difference in the paradigms is indicated in the expressed view that ‘mind body’ is ‘holistic’ and the questioning of the appropriateness of scientific research for aromatherapy practice as a holistic practice. Thus a second false consciousness is revealed related to the aromatherapists expressed felt dissatisfaction and research paradigms.

This felt dissatisfaction can also be seen to have developed out of a lack of clarity of the basic principles of practice, which is likely to have been influenced by the crossing between paradigms in the historical development of aromatherapy practice as well as the cultural dominance of analytic approach. While this confusion between paradigms continues aromatherapy practitioners are likely to continue to experience the double bind and have issues in developing the knowledge required to allow aromatherapy practice to gain the desired recognition. To alleviate this felt dissatisfaction greater clarity of the underpinning principles of practice and how they related to research methodology will greatly assist the development of a path for knowledge development that maintains the integrity of the practice.

Alternatively if aromatherapy practitioners fail to deal with the false consciousness and continue to maintain that aromatherapy practice is a profession, or deal with the perceived double bind the felt dissatisfaction is likely to intensify. This is because as the aromatherapy practice develops, providing the potential for aromatherapy practice to be increasingly used in health care, demands to meet the requirements of a health care modality for EBM will increase. Further the frustration experienced due to not being recognised as members of a profession could become more frequent as they interact with other health care practitioners. As a consequence it is going to be increasingly difficult for the false consciousness, that aromatherapy is a profession, to be maintained emphasising the necessity to deal with the issue. Similarly there will be increased pressure to meet EBM requirements and thus deal with the ‘research/ practice integrity’ issue.

II Potential Professionalisation Pathways

For aromatherapy practice to choose the most appropriate pathway for its development it needs to be aware of the options for the professionalisation or development of aromatherapy practice in health care. A number of options that emerged from the data and literature will be outlined as well as the requirements and associated considerations, in terms of where aromatherapy practice currently stands and what it needs to do to achieve the target outcome. The first considered option is to professionalise as a traditional profession, or semi-profession. Following this is the option to professionalise as a contemporary profession. Another option is to professionalise for standardisation only, without intending to become a profession as such.

To professionalise in accordance with the traditional view of a profession

Professionalisation is generally an attempt to gain recognition as a 'profession' with the associated privileges. To professionalise as a traditional profession aromatherapy practice must develop the core criteria of a profession and deal with issues it may encounter in doing so. What follows is an outline of the traditional professionalisation process related to Morrell's (1999) closure model, actors in the professionalisation process and the core criteria of a profession for aromatherapy practice.

Morrell (1999) described four phases of the process of closure²². Aromatherapy practice can be seen to have reached the second of the four phases due to the development of associations for the purpose of registration. The lack of a dominance of registered practitioners compared to unregistered practitioners indicates that the occupation has not yet moved into the third phase. The lack of commonality in ideology is one reason for relative low membership of the practice's associations. The formation of a break away association in Australia supports the view that there is a lack of commonality in the industry, as does the diversity in participants' views on aromatherapy applications. Low membership may also be due to a lack of benefits to members, as these are an important draw card to encourage membership in an association (Carlton, 2003). Thus there is a need to create commonality and benefits for members to increase practitioner registration and allow the next stage of closure to be achieved.

²² See pg 88

Actors

Professional associations provide a means to support internal cohesiveness and external recognition and are a very important actor in the professionalisation process. It is possible to assess an occupation's development in the professionalisation process via the association. Burrage et al. (1990) distinguishes professional associations from other occupation organisations by 'persistence' in the form of a stable ideology and 'proximity' where practitioners argue that they know the occupation's knowledge best. Consistent with the argument that aromatherapy's ideology is not adequately clarified it follows that the practice does not have the bases for the 'persistence' criteria. Further as the knowledge of aromatherapy practice is widely available and easily grasped any claims of knowing the knowledge best are weak. From this perspective aromatherapy practitioner associations need to develop a stable ideology and secure the occupation's knowledge base in any attempt at professionalisation as a traditional profession.

Another way to assess a professional association is by considering the operation of the association. Turner and Hodge (1970) suggested the use of either the 'community' approach in which members' relationships are examined by considering qualities such as sense of community, sense of identity, common values or duration of membership. Or the 'formal' approach in which organisational mechanisms such as enumeration, registration and licensing are considered. Via the formal approach an association's structures including codes of conduct and ethics, process for registration of practitioners and training institutions are considered as indication the association has the organisational mechanisms required for a professional association.

Aromatherapy practitioner associations have developed codes of conduct and ethics, they have registration processes for practitioners and institutions indicating they have at least some of the organisational structures for a 'profession's' professional association. However when examining the community approach from interview data it can be seen that meeting the criteria of a profession's professional association is undermined. For the interview data note a number of points of practitioners' dissatisfaction with current association(s). These included a concern regarding the current direction of the practice's development, the lack of much needed promotion of the occupation and lack of support to the members. It is important for the associations to deal with the dissatisfaction and build a greater sense of

community and common values as part of the process of attracting and keeping members for the process of professionalisation.

According to Burrage et al. (1990) it is very important for the professionalisation process that practitioners are united. Practitioner unity is described as the first step of professionalisation with commonality in the ideology being described as the key factor for development. To professionalise aromatherapy must determine and clearly articulate its service ideology such that practitioners can unite and develop commonality. At which time it will also be easier for the association to promote the market value of the occupation and develop 'persistence'.

To do this aromatherapists will need to overcome the distrust observed during participant recruiting. Distrust easily leads to a lack of sharing concerns which ensures that any issues that may result from different views do not have the opportunity to be resolved. Thus conflict continues and the unity required for professional development is not obtained. This must be overcome before professionalisation can be successful.

Professional associations and practitioners are but two of the actors in the professionalisation process. Other actors include the public, other related professions, the state and training institutions. As an important source of service users the public are significant actors, indeed Morrell (1999) argues they drive the professionalisation process. To utilise the service the public need to be aware of both the service and its value to them. It is acknowledged that aromatherapy practice has a low degree of recognition and tends to be perceived as a commercial or 'nice smell' venture reinforcing the need to clarify and promote aromatherapy practice's service ideal and value.

To promote aromatherapy practice successfully to the public, other related occupations must be considered. For if aromatherapy practice is perceived as a threat to another profession's monopoly of the market then it is very likely that professions will resist aromatherapy's attempts to emulate them. According to Goode (1969) it is critically important that an aspiring profession, such as aromatherapy practice, establishes its value and credibility to established professions in a non threatening manner. Indeed if aromatherapy practice succeeds in promoting itself in a non threatening manner it may gain support for its professionalisation. Consistent with professionalisation being rooted in

specialisation it is very important that aromatherapy practice develops itself distinctly from other health care practices if it wishes to develop as a profession.

Universities, as an actor, play a role in training practitioners and performing research for knowledge development. As educational institutions, in Australia, universities are increasingly open to complementary therapies, for example Southern Cross University's Bachelors of Natural Therapy. However they do require a standard of knowledge and training for course entry. With aromatherapy moving forward in the process of obtaining Government pre tertiary accredited courses, they may fulfil this requirement and thus have the potential of upgrading the qualification to tertiary standard. To what degree the universities will support the development of aromatherapy practice knowledge is also of importance as the up grade course, as offered by CSU, is a generalised qualification, not aromatherapy specific. For a university to develop a specific course there must be adequate specific knowledge and a demand for the course (it must be economically viable).

Finally, with regard to actors, the policies of the state are significant for the professionalisation of aromatherapy practice. The occupation is dependent on the state for its autonomy. Australian policies promote a balance between competitiveness in the market place and safety for the public²³. This ensures the need for a significant 'risk' and demonstration that training reduces the risk. TCM demonstrates the fulfilment of this requirement and has been regulated in Victoria. However aromatherapy practice is presented and believed to be a relatively safe practice, with the possible exception of the oral use of the essential oils. The recognised risk of oral ingestion of essential oils maybe adequately catered for by current TGA requirements. If so the Government's role of protecting the public may be adequately fulfilled for aromatherapy practice.

Knowledge a core criteria

A profession requires a recognised body of specialised knowledge at tertiary level, that is complex and beyond the reach of most people, in a unique privilege zone, organised into a theory which is at least perceived to be able to deal with a life problem encountered by most people. To maintain the privilege zone the knowledge requires continual development. This monopolised knowledge base ensures a service to most people that

²³ See Page 32 Regulation of CAM practitioners

require them to turn to practitioners to effectively solve a problem. This knowledge is the first core criteria of a profession.

It has been mentioned that the potential for tertiary qualification in aromatherapy is there as part of a complementary medicine health science course. The ratio of aromatherapy specific knowledge in these courses is of importance as it represents the unique specific knowledge of the practice. Currently aromatherapy practitioner training is being processed within the Government accredited national vocational training and has a low number of aromatherapy (field specific) core units. Less than 50% of the proposed content of the aromatherapy practitioner courses is aromatherapy specific knowledge (CSHISC, 2006). The addition of other non specific knowledge, to gain tertiary qualification, will reduce this percentage even further. This provides strong evidence that there is not a large unique body of knowledge for the occupation.

This maybe part of the reason for aromatherapists' concern over 'padding out of training,' or it maybe that aromatherapy is just not distinct enough to develop its own practice related knowledge over and above required health system knowledge. In a similar situation representatives of the mediation occupation argued against professionalisation of the occupation as it does not have a distinct knowledge base²⁴, the occupation utilises knowledge from a number of fields. Aromatherapy practice must develop further knowledge to ensure a level of indeterminacy in order to become a traditional 'profession'.

Scientific knowledge developed by research is the current requirement for health care occupations and professions. The stated intention of this approach is to ensure a safe and effective service and requires all health care practices to move toward the development of an evidence based practice. Further the values of professionalism and the provision of best practice also calls for the development of practice knowledge. The development of an appropriate scientific knowledge base requires research and would provide a basis for informed choice as recommended by the AMA (AMA, 2004).

Some aromatherapists agree there is a need for research to deal with issues of unreliable misinformation and demands by the biomedical profession. Indeed aromatherapy

²⁴ See page 103

practitioners encourage the development of its knowledge base via research. Yet concerns about the appropriateness of research for aromatherapy practice are expressed, as EBM requires analytic research and assumes a causal reality in the therapeutic practice. Currently calls for research focus on causal relationships with the demands for high level clinical trials (MacLennan 1999). The issue of the appropriateness of analytic research is based in the argument presented by aromatherapists that this research methodology is inappropriate for aromatherapy practice due to the practices holistic nature. This is an important point as it may require surrendering core principles of practice (Grant, 2003b). If surrendering of core principles is required then the demands for EBM equates to integration by absorption. This risks the loss of the essence of a holistic practice.

However it has been noted that aromatherapy practice utilises body mind medicine as ‘multi dimensional’ which is understood in terms of causal relationships and thus analytic scientific research is indeed very appropriate. Alternatively if aromatherapy utilises holistic principles in its practice other forms of research may be more appropriate. This is an important issue for holistic CAM practices which may result in choosing not to professionalise as a traditional profession as a result of considering the appropriateness of research for the occupation.

Evidence based medicine’s disregard for empirical wisdom (Grant 2003b) is also an important consideration. The idea of a single form of knowledge as the only appropriate criteria undervalues other forms of knowledge including the lived experience, wisdom and humane caring. Lipp (2003) argues for clear distinctions between EBM and clinical effectiveness with the view that EBM is only one aspect of clinical effectiveness. This also points to arguments on the inadequacy of the medical model and its avoidance of subjective meaning which creates tension between technological and humane care. Importantly the value of scientific knowledge over other forms of knowledge has been argued against, asserting scientific knowledge is a form of power rather than a more accurate form of knowledge.²⁵

Nor can it be forgotten that the majority of medical knowledge does not meet the criteria for EBM. It is acknowledged that medical practice is only loosely based on EBM (RACGP,

²⁵ See page 113

2000a/b). This is in part because EBM is a relatively new requirement in health care practice. By demanding that alternative health care modalities met a high standard of EBM prior to recognition, medical practice is questioning these therapies harsher than it self (RACGP, 2000a). It also sets up an illusionary bench mark as a 'standard' that developing CAM must meet or at least aim for, when biomedicine does not meet the standard. Another concern with this approach is the risk of condemning modern day Galileos (RACGP, 2000a) by reducing innovative practice as part of conserving scientific objectivity and thus restricting the development of new practices.

It can be argued that the demand for EBM is too harsh and progress ought to be adequate as demonstration of professional stance which allows for innovation in knowledge development as aromatherapy moves to 'fit in.' However in support of the development of EBM Howard (1998) argues for the establishment of an evidence base prior to professing to have the knowledge and ability, as indication of the use of higher integrity than previous established professions, including biomedicine, have. The ideal of waiting for adequate evidence for integrity may result in an extremely long development period and begs the question of: what is adequate, especially when biomedicine does not meet the criteria itself.

Nevertheless to professionalise, aromatherapy practice must address the issue of developing its knowledge base via research. To do so it is necessary to address the issue of appropriate research methodology and the issue of resources to do so. Thus as a practice it is important for aromatherapy practice to establish appropriate researchers, ideally trained in both aromatherapy and research; an organisation to support the research and of course funding to carry out the research.

The lack of adequate scientific knowledge in aromatherapy practice is currently worsened by a perceived lack of critical thinking by the occupation's members. Interview data indicated that aromatherapists are seen as over enthusiastic, which can be seen as reflective of Howard's (1998) mention of 'gurus' in the field with an over enthusiastic attitude that is a disservice to the occupation's recognition. Whilst he is referring to psychotherapy the same principle may apply to aromatherapy practice. As part of the professionalisation process it is vital that aromatherapists as individuals and as an occupation develop critical thinking skills. This is vital to assess and develop the practice's knowledge base in relation to the practice and its underlying principles. A critical approach also reduces the risk of any

aggrandisement of aromatherapy practice which provides a means for established professions to discredit the aspiring occupation.

Service ideal a core criteria

A service ideal is the second core criteria of a traditional profession. It is important that as a profession aromatherapy practice's service to society is grounded in a higher ideal that is intended to serve others by providing solution to their problem. In clarifying its service ideal it is necessary for the development of a distinctly different service to reduce related professions reacting to any perceived threat to their monopoly. Further aromatherapy practice needs to distinguish itself as a therapeutic practice from other forms of aromatherapy. At present aromatherapy is not distinguished from nice smelling commercial products, consequently its potential value as a therapeutic service is undermined.

The service ideal 'health care' already has an established dominant profession, 'biomedicine' and semi-profession, 'nursing'. There are also a number of established associated or allied professions. In health care the medical profession and nursing practice are the two most related established health care modalities. Research shows that whilst some practitioners of these practices do not see any value in aromatherapy there is also some support for aromatherapy practice²⁶. Nursing supports the development of aromatherapy possibly due to a similar philosophical underpinning (Johnson, 1995). With these two recognised health care practices well established it is important for aromatherapy to be careful in its development if it intends to develop the monopoly required to obtain profession status.

It is possible to develop a service distinctly different from biomedicine, in health care, as done by chiropractic and TCM. These fields were originally seen and treated as threatening and had some difficulties gaining recognition, however their recognition sets a precedent for health care practices that are different enough, especially philosophically, from biomedicine to be granted recognition. Nursing still struggles for its independence from the medical profession as it appears, according to literature, to not have distinguished itself enough from the medical profession. It is critical therefore to show aromatherapy is not a

²⁶ See pgs 53 Recognised and valued application

threat to medical profession or other health care practices whilst providing a valuable service of its own.

Meeting the criteria of a profession requires aromatherapy practice to develop a clear unique and valuable service, as well as an appropriate knowledge base. Control by monopolisation and autonomy is the third core criteria of a traditional profession. For this aromatherapy must monopolise and control both the knowledge base and the service. For autonomy to be legitimised by the government in Australia the demonstration of significant risk is required.

Professionalisation as a semi-profession

According to Simpson and Simpson (1969) a semi-profession is distinguished from a profession by the lower degree of autonomy and or by having humanitarian principle underpinning the service. Thus generally to develop as a semi-profession an occupation must still develop an appropriate knowledge base, service and control of the occupation, as for a traditional profession. However a different philosophical approach to its practice is taken or the occupations fails to achieve full autonomy.

A traditional profession is based on the idea of experts providing service to clients based on the premise that the expert knows best and thus can determine the problem and solution. Objective disinterest is seen as the best way to provide the service and obtain the desired outcome, personal considerations are inappropriate. The structure of a traditional profession is hierarchical with the client expected to do what they are told. Alternatively a semi-profession practitioner relates to the individual, valuing individuals, relationships and subjective considerations they follow a humanitarian approach yet have the same requirements for knowledge, service and monopolisation (Simpson & Simpson, 1969). However if the primary distinction is that of the philosophical underpinning perhaps a new concept of a profession is a pathway to consider.

To professionalise as a contemporary profession

According to Bertilsson (1990) and Reece (2003a) what a profession is recognised to be is an evolving process and with the turn of the 20/21st century questions of what a new profession may be are being proposed. A dominant approach in this process is to question which of the core criteria are really essential for a profession and which could be made

obsolete. Due to the high level of criticism directed at the authoritative stance the most likely development of a contemporary profession is the alteration of the authoritative philosophical stance to a humanitarian empowering philosophy. This may appear to be the same as a previously described semi-profession. However it has also been noted that for an occupation to have integrity with this philosophical approach it would be necessary for it to adjust the institutional structure, as current institutional structures are of the hierarchical nature reinforcing 'power' relationships and undermining principles of empowerment (House, 1995; Mowbray, 1995).

The process of establishing appropriate institutions for a contemporary profession would realign professions from an authoritative institution which reinforces dependence, to empowering institutions that are underpinned by 'meaning' 'growth' and 'personal competence' promoting increased personal autonomy. Such a profession would not be based on a need to control but mutual recognition and knowledge. The service provided by such professions would empower individuals to act in an informed manner. Respecting both individual's ability to make the right choice for themselves and professionals for the knowledge and skills they are trained in.

Another important issue for a contemporary profession (indeed all professions today) is the ethical considerations of duality, between public service and market position (Grossman, 2003). This issue is of importance as the concept of a 'profession' today is more related to a business than service, in the traditional sacrificial manner, and the need for new ethical standards to distinguish service/business is argued for (Reece, 2003b). This is particularly important as the indication is that aromatherapy practice's professionalisation is underpinned by a desire to secure an income for aromatherapists.

This issue high lights the importance of an accountable and credible practice as the principles that drive the 'revolt of the public'²⁷ ensure that all practices will be questioned and required to meet public scrutiny. Bringing us to the question of what is a credible service? While health care emphasises the need for EBM, the demand for EBM is criticised²⁸ and it is argued that efficiency is not the only measure for assessment of professions as the social context, common good and dignity of individuals are also

²⁷ See page 75

²⁸ See page 207

important considerations (McGettrick, 2002). McGettrick (2002) argues that professionals have the responsibility to act and support other's acting in others interest, not just their own.

The issue of duality also highlights the need for new ethical standards²⁹ requiring individual practitioners to clearly declare their own values, empowering potential clients to make informed choice of practitioner and to deal with inherent conflicts of the profession cum business. It is argued that a practice that is driven by purely economic reasons is harmful and professionals need to explore and clearly define their values as a step in re-invigorating economic and social good (Reece, 2003b).

Thus for the option of developing as a contemporary profession aromatherapy practice must still develop an appropriate knowledge base and unique service as for a traditional profession, while maintaining integrity with an underpinning philosophy that supports a practice of empowerment and deal with issues of duality. Thus it has the added challenge of developing a new model of institution based on the empowering humanitarian paradigm and issues of duality. Tackling this process will challenge practitioners to deal with dynamics of power and its shadow victim hood, as part of the development of a new model for institutions and professions, in addition to establishing a unique and valued service and appropriate knowledge base.

To professionalise for the purpose of setting standards of practice

Another pathway for the professionalisation of aromatherapy practice is the standardisation of the practice, without the intention of reaching for the goal of becoming a 'profession'. This pathway uses principles of professionalisation to create a well defined and standardised practice that does not require the same level of knowledge and training as a profession. This process can assist the occupation to gain recognition as a viable health care 'occupation' with less stringent requirements and level of training than a profession and can be utilised as a step toward professionalisation as a profession or as an end in itself.

The Australian Government's national vocational education and training system provides a means for an occupation to begin the professionalisation process for standardisation of the

²⁹ See page 77

practice. The idea of professionalisation for the purpose of standardising is a fairly assessable pathway in Australia via the National Vocational Education and Training system (VET). Indeed aromatherapy is progressing down this pathway with accredited courses in aromatherapy practice at the Certificate IV and Diploma levels being developed. However the TAFE system is a competency based training system designed for specific workplace performance, which is distinct from university education which is based on abstract systematic knowledge. The development of critical thinking skills and the continued knowledge development via research is part of the university system (AQF, 2006) and a requirement for a 'profession'. Thus progression through the VET system requires competency based training to evolve into an education that is designed to enable individual's to access, assess, develop and implement knowledge in an accountable manner.

Whether aromatherapy practice utilises this standardisation as a step toward becoming a profession or simply for standardisation it is still necessary for the occupation to develop its knowledge base to the appropriate level and deal with the apparent double bind of gaining recognition and remaining true to the principles of practice. A logical process for the knowledge development is for individuals to train as aromatherapist upgrade this qualification to a degree and go on to do post graduate research on aromatherapy practice. This provides a pathway for aromatherapist to do the required research for aromatherapy practice's development.

III Alternatives to professionalisation

When considering options for the development of an occupation it is also worth noting that professionalisation is not the only option. An occupation could develop rejecting the framework of professionalisation and remain as individual practitioners, perhaps with a practitioner support network. Alternatively aromatherapy practice may choose to develop as a tool for other health care practices.

Develop as independent practitioners

House (1995) suggested an occupation could develop as independent practitioners. The model he presented included independent practitioners united as a network of practitioners. However practitioners could practice totally independently. Either of these approaches avoids restriction on development of free thinking (Carillos & Zazzaro, 2001) and thus is supportive of a diverse range of practitioners as is seen in aromatherapy practitioners today. Indeed aromatherapy practitioners, in Australia today, are largely independent practitioners as despite the two associations in Australia many (trained) aromatherapists are not members of either association.

This non regulation approach is recommended by some members of the counselling profession (House, 1995, Mowbray, 1996) arguing that regulation harms as it encourages dependency on a system of claimed experts and reduces self dependence and the ability to make the most appropriate choice for oneself. This approach promotes education on how to make informed choice, to support empowering individuals and maintain integrity with the principles of the practice. This approach requires individual practitioners to be responsible for the provision of a valued service and the quality of their service. In this way they are truly market driven for they must provide a quality valued service to survive. When there is minimal risk in the practice, as with aromatherapy the option of practicing as independent practitioners is a reasonable option. This approach of independent practitioners does not support development of knowledge for the occupation as there are unlikely to be structures in place for knowledge development.

Develop as a tool within other occupations

Another alternative is for the occupation to consciously partake in the integration of the practice into other health care modalities, as aromatherapy practice has historically done. The development of aromatherapy practice in other modalities involves the development of specialist knowledge for each occupation for example nursing, midwifery, psychological practices, naturopathy, or TCM. Consequently this approach still requires the development of an appropriate knowledge base however its development may be supported by those within the individual fields relating the essential oil use to the specific practice. This pathway for the development of aromatherapy is within health care modalities rather than as a unique health care modality.

Table IX provides an outline of the requirements for each pathway for development explored. It can be seen that each pathway requires a service and that the other criteria discussed vary between the pathways. A higher degree of knowledge is required for all professions than the other pathways and monopoly is only required of the fully developed professions. However the philosophical underpinning varies between and within the pathways yet is a critical issue for all developing occupations as it underpins the very service provided and thus ought to influence knowledge development and choice of pathway for development.

Table IX

Requirements for each pathway: The requirements for six potential pathways for occupational development related to three core criteria of a ‘profession’, an advanced knowledge base, a service, monopoly and philosophical underpinning are listed. An ? indicates that the criteria may or may not be essential for that pathway.

	Advance knowledge	Knowledge	Service	Monopoly	Authoritative Underpinning	Humanitarian Underpinning
Traditional Profession	Yes		Yes	Yes	Yes	
Semi Profession	Yes		Yes			Yes
Contemporary Profession	Yes		Yes	Yes		Yes
Standardisation		Yes	Yes		?	?
Individual practitioner		?	Yes		?	?
Tool		Yes	Yes		?	?

Source: this table was created by the author.

IV Which Pathway

In accordance with the principles of critical theory the focus of this study is the empowerment of the aromatherapy occupation by revealing oppressive beliefs and to support them finding the motivation and means to do something to overcome the oppression. Thus the intention of this study is to provide information and options for

informed proactive choice for aromatherapy practice. To recommend a particular path of transformation is not in line with this study's intention nor is it consistent with the underlining principle of empowerment. It is up to the occupation, the practitioners and the association as a representative of the practitioners of the occupation to determine what it is they want, are able and prepared to do for the occupation's development. When considering the choice of pathway key issues that need to be considered include the expressed felt dissatisfaction and the appropriateness of professionalisation.

Felt dissatisfaction

Assuming the reason for professionalisation is an attempt to deal with the felt dissatisfaction of the practitioners the felt dissatisfaction is a key consideration. The felt dissatisfaction of the aromatherapy practitioners has been outlined to be due to a lack of recognition for the therapeutic value of aromatherapy practices, for aromatherapy practitioners and the desire to remain true to the essence of the practice whilst gaining recognition. To gain recognition aromatherapy practice as an occupation needs to establish credibility, promote its service and preferably secure support from an established profession. To remain true to the essence of the practice the essence must be clearly defined. This points to the key issue for the occupation's development, the proposed occupation 'identity crisis'.

The identity crisis in aromatherapy practice has been outlined to be the result of the lack of a clear united and articulated practice definition and underpinning framework, including philosophical underpinnings, paradigm and appropriate methods of application. The need to distinguish aromatherapy practice from other modes of aromatherapy, as well as other health care modalities needs to be considered in this process of clarification, as does the current diversity of aromatherapy practice for the diversity needs to be either included in the definition or standardised out. As stated by Schnaubelt (1999) 'aromatherapy needs a theoretical framework as a platform to develop with self confidence without authorities' approval'. A service that is well marketed and knowledge development will be the most powerful ways to enhance the potential for recognition of aromatherapy practice.

The debate on the therapeutic value of aromatherapy, along with noted concerns about misinformation, highlights the need for practice related knowledge to support therapeutic claims in order to establish aromatherapy practice as a credible practice in health care.

Practice related knowledge requires the knowledge to be developed related to the principles of practice including the philosophical underpinning and the methods of application. This emphasises the importance of defining and articulating the practice for knowledge development. It is important that the developed knowledge directly supports and relates to the practice to avoid the theory practice gap. It is also important that the most appropriate research methodologies are used for the knowledge development. Further in the Australian health care system the current form of credible knowledge is EBM. The requirement of an appropriate knowledge base and research must be dealt with one way or another.

One way for aromatherapy as an occupation to resolve the felt dissatisfaction and increase the desired recognition is to develop the practice knowledge base by encouraging members to up grade their government recognised qualifications, once available, to degrees and then going on to research as part of post graduate study. Aromatherapists are more likely to be able to develop research that is truly practice related and able to support future recognition of the practice. However the appropriateness of professionalisation must be considered.

Appropriateness of professionalisation

Aromatherapy as a developing health care modality has, at least in theory, a number of options for its professionalisation or development. The practice's professional association can aim to move the practice toward becoming a traditional profession, a semi-profession, a contemporary profession, or professionalise purely for standardisation of the practice, develop as independent practitioners or as a tool in other occupations. While each option has its own individual requirements they all require aromatherapy practice as an occupation to meet two basic requirements, the clarification and defining of the practice and its service plus the development of an appropriate knowledge base for the intended outcome. Previous discussion demonstrates that both of these requirements need significant progress in order to meet the requirements of a profession of any sort.

Steps for professionalisation have been outlined with an underlying assumption that an occupation can travel the path of choice; all it need do is fulfil the stated criteria. However it has also been noted that professionalisation is often unsuccessful. The reasons for this are generally due to the fact that occupations are attempting professionalisation in a socio-political context. There are at least five main issues for consideration within the socio-political context: public demand; the transparent requirements of the system; power

relations within the system; the occupation it self; its primary goal and; available resources. These are the social confines which a developing occupation must operate within.

Meeting the transparent social requirements presents a significant challenge for aromatherapy practice due to the degree of difference between where it is at and where it needs to be to become a profession. The first issue is the significant difference between the required level of knowledge and what aromatherapy practice has. That is there is not a level of indeterminacy for the occupation to build on. The process of developing an appropriate knowledge base would require vast resources including time. As a second point it is also necessary to demonstrate a significant risk associated to the use of the occupation's knowledge and that occupational training reduced the risk. As aromatherapy practice is considered a relatively 'low risk' practice this point creates a second a major obstacle for becoming a regulated profession.

Dealing with political power relations is also an important consideration as the occupation is not adequately distinct from established health care practices to establish a unique valued service. This ensures that if aromatherapy practice developed such that it caused a concern to established professions then these professions are very likely to resist the occupations further development. At the present aromatherapy practice does not present a threat in any way to established professions.

The biggest issue for aromatherapy practice, which must be overcome before any of these issues becomes significant, is the occupations 'identity crisis'. Just what service aromatherapy practice may provide (or how) is not clear, united, nor distinct from commercial enterprise. Once aromatherapy practice determines its underpinning principles of practice, in a united manner, it must then consider the appropriateness of each pathway related to these principles in order to ensure its development maintains integrity with the practice. Another consideration for the appropriateness of professionalisation is the occupations lack of resources to attempt professionalisation.

As a consequence of these considerations in reality it is not practically possible for aromatherapy practice to effectively tackle any of the pathways of professionalisation other than for standardization. This leaves aromatherapy practice with the realistic options of

professionalisation for standardisation, development as independent practitioners or to consciously partake in its development as part of another occupation(s).

Most likely pathway

Still these potential pathways assume and require aromatherapy practitioners and associations take an active role in the occupation's development. Importantly, there is an acknowledged lack of unity and even apathy noted by members of the occupation. This lack of unity prevents the professional association(s) from acting in a powerful way for the development of the occupations recognition. So it becomes important to ask; is there yet another alternative future for aromatherapy?

Aromatherapy has a history of being used as a tool within other practices, whether it is medicine, beauty therapy, massage or even veterinary. Further with a matching philosophical approach (Johnson, 1995) nurses are already researching and have entered a debate on the use of aromatherapy and related accountability (Mackereth, 1995) demonstrating that integration into nursing is in progress. For nurses the integration of aromatherapy, and other CAM, into their practice could provide the added bonus of increased independence for nursing practice, something the occupation has been striving for.

Nursing practice's tendency to develop specialist area by further training, and experience in developing practice knowledge provides them with the framework to carry out the integration process. Indeed a nurse participant pointed out the need for the resources to facilitate the process of professionalisation and that nursing has supported naturopathy's professionalisation, in turn demonstrating the occupations expertise and willingness to partake in such development. Not only does nursing as an established semi-profession have the interest, relevance and experience they also have the resources to facilitate the process including to research and develop practice knowledge. Consequently it is suggested that the most likely pathway for the development of aromatherapy in the Australian health care system is within nursing practice.

By presenting this pathway as the most likely it is not to say this is the way it will happen, the future is always open to choice and powerful action. That aromatherapy practice is moving towards standardisation with the development of government accredited courses

shows that aromatherapy associations are taking action for the occupation's professional development. However nurses do establish fields of speciality by taking further course, usually specifically designed, and the aromatherapy accreditation can just as easily facilitate the process of integration into nursing as aromatherapy practice's unique development. Currently aromatherapy is not distinct enough in its service to limit such an integration process.

Another option was suggested, in that the medical profession could take on the oral and medical use of essential oils (aromatherapy) in their practice. However there is no evidence of interest by the medical profession to take this role on. Yet another possibility is that naturopathy or Western herbal medicine modalities could also consider the role. If these options are acted upon they are likely to take a distinctly different approach from the nursing approach. With nursing much more likely to emphasis the nurturing and self care qualities of aromatherapy practice and naturopath or the medical profession the medical task orientated approach.

Summary

The study found that aromatherapy practice's development in health care is driven by the perceived value of aromatherapy practice by both aromatherapists and interested nurses. Aromatherapists are also driven by the desire to create a market for the practice in order to secure an income. There is a risk that the professionalisation of the aromatherapy occupation maybe driven by fear related to the felt dissatisfaction associated to lack of recognition and desire to secure an income by aromatherapists. The study also reveals that aromatherapists' desire for recognition for the practice establishes a perceived double bind for them as they also wish to maintain integrity with the 'essence' of the practice this concern acts as a counter balance to the occupations development by aromatherapists.

For aromatherapist felt dissatisfaction to be effectively dealt with it is necessary for aromatherapy practice to deal with the occupations 'identity crisis' and clarify the practices service, value and underpinning philosophy. This would provide the practice with a basis for its occupational and knowledge development whilst maintaining integrity with the 'essence' of the practice. Until these two illusions are addressed the felt dissatisfaction of

aromatherapists is very unlikely to be relieved despite the possibility that aromatherapy practice may develop within the health care system.

It is also necessary to deal with these issues for all four potential pathways for professionalisation of aromatherapy practice outlined: traditional profession; semi-profession; contemporary profession and; standardisation. While the transparent socio-political requirements varies with each pathway the core criteria for each include the development of an appropriate knowledge base, a service that is distinct and valued and monopolisation of the practice's knowledge, skills and service. However it is very unlikely that aromatherapy practice will be successful in attempts to professionalise, other than for standardisation, due to the significant difference between what is required of a traditional, semi or contemporary profession and what aromatherapy has to offer in regards to the criteria. As an example of a CAM occupation attempting to professionalise aromatherapy practice shows the challenge that such occupations have to face.

Two alternative pathways for aromatherapy practice's development also emerged in this study. Aromatherapy practice may continue to develop as independent practitioners or as a tool within other practices. The data shows that the development of aromatherapy practice is likely to occur within nursing practice due to this occupations interest, philosophical match, established resources and skills for knowledge and practice development. It is also necessary to consider that not all or possibly not even key nurse practitioners are interested in the use of aromatherapy and thus its integration into nursing practice. Thus the development of the occupation via individual aromatherapist practitioners is also possible. By recognising the issues related to the felt dissatisfaction and dealing with them in order to market themselves as a business with a service to provide individual practitioners are more likely to relieve their personal felt dissatisfaction (indeed what the aromatherapist in the study, who are more content, have done).

Importantly the issue of the double bind between knowledge development and philosophical mismatch highlighted in this discussion also indicates a potential mismatch between the philosophical base of the practice and a traditional profession. In noting the issue of the underpinning philosophical mismatch between traditional professions and aromatherapy practice the awareness of an illusion in the development of CAM in the

health care system was revealed. This is the focus of the next chapter, noted as the revealed illusion.

Chapter 12

Revealed Illusion

The goal of science informed by critical theory is the creation of a more just society resulting from change brought about by education and praxis resulting in the emancipation and liberation of the oppressed. Thus it is committed to expose, critique, and discard false consciousness resulting from overt and covert power imbalances sustained through social structures. By historicizing the sources and motives of prevailing ideas and practices, it critiques ideology while remaining intensely skeptical of surface appearances. Digging beneath the surface provides a means by which people can radically alter any false self-conceptions.

Fontana, 2004

Perhaps the ills of the health care system itself may be alleviated by balancing its approach to its own development. It seems apparent that it is time to rethink the use of singular, polarizing and uncompromising paradigms.

Yacopetti, 2000; 2

The last chapter considered the professionalisation of aromatherapy practice in health care as a means to address aromatherapist felt dissatisfaction. As part of the felt dissatisfaction the perceived double bind of gaining recognition, while remaining true to the essence of the practice needed to be addressed. The process of reflecting on the issue of the difference between the holistic and analytic paradigms and what the public is asking for in health care revealed an illusion that may prevent the effective ongoing development of the health care system, where the effective development refers to the improvement of the service in order for it to meet public requirements. It is suggested that the action being taken by the biomedical profession, to deal with the current health care crisis, will not effectively address the felt dissatisfaction of the public and as a consequence is unlikely to resolve the increased demand for CAM. This chapter intends to examine the revealed illusion and explore what the health care system could do to address the public's felt dissatisfaction.

I Felt Dissatisfaction and Revealed Illusion

The social crisis identified in this study is within the health care system due to the increasing demand for CAM practices with people reclaiming their right of choice in health care. Evidence³⁰ shows the public demand is, in part, out of an expressed dissatisfaction with biomedical health care. This felt dissatisfaction is due to a failure of biomedicine to address issue of health for the people as individuals. Having failed to provide the 'magic bullet' promised, the biomedical profession now is in danger of losing the profession's dominant and authoritative status. People no longer accept the view that biomedicine will cure all and are turning to CAM wanting to be heard and make choices in order to have a better quality of life. There is hope or experience that CAM, with its claimed holistic approach, is better able to fulfil or at least complement this desire.

Due to the increasing demand for CAM the biomedical profession has moved to integrate select CAM services into its practice. Integration is undertaken by demanding that CAM practices meet biomedical stated standards of evidence of efficacy and safety, professionally appropriate demands. Yet at the same time it is important to remember that biomedicine itself does not fulfil the demands³¹. Further the standards set by the medical profession are based in assumptions of casual reality, normalisation and an understanding

³⁰ As discussed in chapter one

³¹ See page 24

of reality as a fixed physical one based on the 'modern' paradigm of science and economic viability. The implication of this strategy is that healing is only in the physical realm, that the public are looking for the physical modalities of CAM and these modalities can be integrated into biomedical practice once found to be therapeutically and economically effective. A lack of research to demonstrate significant predictable effectiveness is used as grounds to discredit CAM modalities.

Yet it has been questioned if the public are actually looking for 'something else' when turning to CAM, such as empowerment and egalitarian consultations (Lewith, 2000). Indeed research indicates that the public turn to CAM due to dissatisfaction with biomedical health care (Wiesner, 1995) and is looking for improved quality of life (Wilkinson, 2001). Indicating that people are moving toward a 'post modern,' anti authoritative approach to their health care as part of a paradigm shift in society.

Coulter and Willis (2004) agree that the change in health care is part of a societal change. However they argue that the causes of the rising demand for CAM is unknown. Acknowledging that there is evidence for a post modern thesis relationship with the use of CAM, they express concerns of drawing causal inferences stating that any explanation needs to take into account patients' increasing ability to make demands and have them met. Other wider aspects of society also found to correlate with CAM use include: increased education, awareness of right to choose, to have quality service and the promotion of personal responsibility in making appropriate life style choices. All these qualities, along with the ability to vote with their money, surely address the issue of individuals' abilities to make and achieve demands. Regardless having a post modern view is an effective predictor of CAM use (Siahpush, 1998)

Like holism the 'post modern' approach acknowledges the role of the mind and thus is seen to counter criticisms of biomedicine's neglect of the human spirit. With research demonstrating the importance of purpose, hope, happiness and personal control in health the criticism that biomedicine is damaging to health due to dependence on experts and the resulting reduced personal control (Illich, 1976) takes on renewed strength and significance. These psychological concepts, the human spirit, are evidently important for

health and are part of the post modern view of life. Indeed the evidence is such that biomedicine is embracing and using them as part of the body-mind approach.³²

Part of the post modern approach is the questioning of dominant scientific ideology and the view that political decisions are often made to support the authoritative expert view. In health care this includes challenging the idea that biomedicine provides the one 'right' solution for 'all' situations. In essence the post modern approach questions assumptions including 'is this service right for me?' This questioning highlights the aspect of spirit that emphasises choice, growth and empowerment of the individual³³.

Revealed Illusion

It is suggested that the revealed illusion is that by providing evidence of effectiveness and integrating the practice or using lack of evidence of ineffectiveness to discredit CAM practice, the threat by CAM to biomedicine will be resolved. However neither the lack of evidence (Coulter & Willis, 2004) nor the integration of selected CAM practices in this way has done anything to stop the rise in demand for CAM. This approach is not resolving the felt dissatisfaction because this approach is based in an illusion that it is 'the physical modalities' that the public want when what they want is for the 'heart to be returned to health care,' a post modern approach to health care. The consumer wants themselves, the individual, to be considered in the health care service so that they are heard and may make choices.³⁴ The observed response³⁴ by biomedicine to the social crisis of demanding evidence of therapeutic effect and to integrate selected CAM into the health care system does not address the public's felt dissatisfaction as it is not addressing the fundamental paradigm shift. Biomedicine has failed to meet its ideal and as the tide turns the human spirit rises.

The illusion is the result of biomedical health care being based in the 'modern' paradigm along with that paradigm's and biomedicine's dominance in society. As a result a lack of distinction and awareness of the different approaches to health care, indeed reality, with the view that the physical causal reality and hierarchical expert view of the modern paradigm, is

³² Noting the difference between body mind and holism see page 15

³³ See page 16

³⁴ See discussion on reasons for CAM growth pages 22-23

the right way if not the only way. A lack of acceptance or awareness that someone else's best interest may not be matching this view is central to the issue.

The continued devaluing of the human spirit prevents biomedicine from seeing the illusion. By insisting this 'modern' approach is correct, or more accurately 'all there is' the biomedical approach continues its attempt to dominate health care. The belief that the 'physical' is all there is and that evidence can demonstrate the 'right' way ignores individuals, their view of reality, their experience and the minority that do not fit nicely in the norm profile. The modern approach is further reinforced by the continued educational focus and emphasis of the approach to knowledge and health care, as well as confusion over what holistic health care is.

It is proposed that biomedicine is addressing the issue from the view of the modern paradigm focusing on a fixed physical reality of casual relationships and has misunderstood the public demand for CAM. It is suggested that it is not the physical modalities that are the central criteria being demanded, rather the people are looking for a more humane and empowering service that relates to their lived experience, empowers them and gives meaning to the health care service as well as their lived experience, aspects of the post modern paradigm.

An alternative view

Featherstone and Forsthy (1997) present 'medical marriage' as an alternative where biomedicine and CAM work together. They argue this approach is better for all: the patient is provided with a better service; the medical practitioner has access to a great range of interventions and reduced pressure, as CAM practitioners take on appropriate patients and; the CAM practitioners have access to academic support and expansion of patients. This approach could deal with the public felt dissatisfaction as their needs are met and CAM practitioners felt dissatisfaction as their service is recognised. At the same time medical practitioners are invited to see perceived threats as values that can enhance their higher ideal 'health care'.

The limited view that health care is a physical activity that has a 'best' approach is contrasted with a view that recognises the value of the two apparently opposing views of reality and health care, what Featherstone and Forsthy (1997) describe as holism at its best.

In this view a post modern approach is taken that allows for multiple realities, lived experience and the tension between technological care and humane care to be attended to. For in true holism all approaches are considered so that the most appropriate course of action for a client can be acted on. Many holistic practices acknowledge the value of analytic interventions when they are required, it is the over use that is a concern and harmful, as Illich (1976) argued. Holism considers the human spirit, the natural ability to self heal, an individual's dignity and right of choice as critical, it also embraces analytic approaches as required. Indeed holism views the analytic approach a valuable part of health care.

For medical marriage to occur it is necessary for practitioners of both biomedicine and CAM to get together, acknowledge the values of each approach and work together in the best interest of the clients and the Australian health care system. The education of health care practitioners of the difference between and values of each approach is seen as core to this approach (Featherstone & Forsthy, 1997). Education for the public in 'how to select the right practitioner for them' and 'how to assess information' (unbiased) on the options that are open to them and a system that supports appropriate research to promote safe effective practice are three steps that will greatly assisted the development of such an enlightened health care system. This approach supports Seedhouse's (1986) view of the importance of recognising and respecting the values of the consumer, that individuals' health care practices tend to relate to their beliefs in other areas of their life (Kermode, 2004) and the blurred boundaries between personal and professional responsibility in health care. There is not one right approach to health care, medical marriage acknowledges this and allows respect and options for the consumer and practitioner alike.

Currently in Australian health care education the value of CAM is being introduced. Care needs to be taken that the education covers the aspects that will support the system in dealing effectively with the public's felt dissatisfaction and not simply fall into the trap of the illusional belief that it is the physical modalities that is being demanded and thus is required. It is also important for holistic practices to see analytic practices as an aspect of holism, for many do use this 'causal approach' in their practice. It is not necessary to discard the 'analytic approach' because it has been associated with the biomedical physical reality view. It is important to distinguish between CAM and biomedicine as approaches to health care and analytic and holistic as underpinning principles.

II Dimensions of Health Care

There are a number of dimensions of practice that are different between the analytic and holistic health care approaches. These are largely different due to the view of reality that either devalues or embraces the human spirit. In Table X the differences between the two philosophical approaches to practice are listed as: client interaction, care, practice intention, practice focus, focus of treatment, mode of effect, agent used and the practitioner's role. It is important to recognise that holism does not discard analytic predictive practices as analytic rejects the spirit, the unpredictable aspect of reality.

Table X
Underpinning principles of health care practice: Distinguishing characteristics of the practice of the two broad approaches to health care are listed.

<i>Underpinning principles</i>	<i>Analytic</i>	<i>Holistic</i>
Client interaction	Authoritative expert	Empowering facilitator
Care	Technological Objectification	Humane Personification
Practice intention	Normalise state Categorising Intervention Predictive	Growth change Personification Vitalism Non predictive
Focus	Disease treatment	Health promotion
Treat	Isolated symptoms condition	As part of a whole
Mode of effect	Biological	Biological Manipulative Energetic Psychological
Agent used	Pharmacological	Natural
Practitioner's Role	Intervene	Model:- self responsibility and self care

Sourced: this table was created by the author.

Client interaction refers to the underpinning view that provides the basis for the relationship interaction. The two approaches are underpinned by the basic views of life which are either a hierarchal or empowering approach. An analytic practitioner operates as an authoritative hierarchal expert who claims to know what is best for the patient and thus takes over and attempts to control the process to obtain a predetermined outcome. In order to achieve the best results for the client, 'objective disinterestedness' is used to solve the client's problem based on knowledge and facts, personal choice, either of the client or the practitioner, ought not be considered (Goode, 1969). Alternatively the empowering facilitator approach, with its unconditional positive regard, moves the locus of control from the expert to the client with mutual responsibility and accepts suffering as part of the lived experience and growth. Holistic practitioners operate as facilitators and protectors of autonomy, choice and empowerment with compassion underpinning their service rather than objectivity. Ideally their training provides them with the knowledge base to inform the client of options in their health care and support them in following the path of choice.

'Care' as a dimension of health care is an aspect of client interaction distinct from the interaction itself, it is about how what is done is done. It is the focus of the debate between technological care and its focus on interventions at the physical level, and humane care that focuses on the individual. A post modern holistic approach aims to deal with the tension between technology and humanity that is seen in the modern approach to health care, which creates tension due to the devaluing of 'caring' and the human spirit. As part of the debate Peacock and Nolan (2000) argue for the return to the use of the human aspect of caring, with caring an essential element of curing.

As a dimension the 'intent of practice' refers to the approach to practice. The analytic interventional approach is based in the predictive nature of causal reality, has the intention of achieving standardised outcomes and returning function to normal. While a holistic approach supports growth and meaningful change which tends to be non predictive, nurturing and accepting in nature, it aims to stimulate the individual's 'self heal' mechanism and encourages individualisation, however uses intervention as required. CAM is associated with differing versions and degrees of vitalism and non predictive practice intentions (Coulter & Willis, 2004) as well as the use of analytic interventional treatments as part of their practice. Holism acknowledges that it is important to stabilise and have

basic health for growth consequently analytic treatments maybe utilised in order to establish basic health as part of growth.

The biomedical practice tends to be primarily 'disease care'. While 'health care' is strongly promoted by holistic practices with disease care utilised when required. The health care focus may include health maintenance or enhancement, utilising life style practices. This approach was seen in traditional TCM where a practitioner was considered to have failed if his client became ill. Biomedicine is seeing the value of health promotion in health care and is increasingly embracing it.

The idea of what each approach 'treats' refers to the principle of practice in biomedicine that reduces conditions down to isolated symptoms and parts of the whole, while holism acknowledges and operates with the whole person, who interacts with and is influenced by the environment. Consequently the holistic approach considers these aspects as part of patient care. This is the aspects that emphasis the multidimensionality of health and life as seen in body mind medicine.

There are a number of modes of therapeutic effect, they can be grouped into three broad categories: physical interventions including biological or manipulative body based practices; psychological interventions which may include mind body practices such as mediation, relaxation or practices such as cognitive (ie cognitive behaviour therapy) or mood based practices such as purpose, happiness and perhaps placebo; and energy therapies which is a broad group with many approaches and theories of effect (Gerber, 1988) which encompasses connection, love, spiritual healing, healing touch, music, colour and subtle energy. Biomedicine practices tend to focus on biological modes of effect while holistic practices embrace all, though specific modalities emphasis different therapeutic effects.

The agent used tends to be distinct between the two approaches to health care, with holistic practices seen to use natural agents while biomedicine primarily uses pharmaceutical or technological agents. It is necessary to make a distinction between natural as the 'product' from natural as in 'vitalism' (natural healing ability) as they are two different dimensions. The first being a therapeutic agent sourced from nature with minimal processing and the second being the innate natural ability of the body to heal itself. As a therapeutic agent

natural medicines can be used in analytic approaches and thus while natural medicines are used in holistic practices, natural medicines do not equate with holism.

Finally in holistic practices the 'practitioners role' as a role model is emphasised and epitomised in the saying 'healer heal thyself.' This practice is noted by Featherstone and Forsthy (1997) as the need for the practitioner to role model and practice what they preach as part of their own healing and growth. Holistic practitioners must be both knowledgeable and demonstrator of the practice. While in biomedicine the focus is on the knowledge base and its use, the role of knowledgeable intervention.

While Coulter and Willis (2004) correctly point out that at some levels the different approaches to health care are incommensurable it can be seen that in practice the approaches are not two totally separate practices. The truth is that some CAM practices that proclaim to be holistic, such as aromatherapy practice, do use analytic approaches in their practice and some biomedical practitioners use holistic principles.

It could be said that a holistic health care practice is one that predominately utilises holistic principles and analytic therapies principles are an aspect of holistic practice. Alternatively an analytic practice is one that focuses on the analytic, physical approach such as biomedicine tends to do. An important difference between the two broad approaches is the reliance of pharmaceutical agents and technological equipment compared to the use of natural therapeutic agents however this difference alone does not distinguish holistic and analytic practices. It does however distinguish natural therapy from pharmaceutical therapies. The essential core difference between holistic and analytic is in the understanding of reality, either embracing or devaluing the human spirit and its role in health and the implementation of this principle in the health care practice.

An enlightened health care system would have an articulated understanding of the difference between the two health care paradigms and use them in the best interest of the clients. Some practitioners would naturally lean to one paradigm and others to the other. Ideally some practices would be multimodal with practitioners working together for the patient's best interest. This would allow recognition of the value of each of the two approaches and provide real choice in health care. The overall effect of increasing holistic

principles in the practice is to humanise the practice, what the public appears to be asking for.

It is argued that the key for dealing with the felt dissatisfaction of the public is in understanding and articulating what each individual practitioner's principles of practice are, as suggested by Reece (2003b) for professions in general. Articulated underpinning principles and values could then be part of the information practitioners, biomedical and CAM alike, provide to the public enabling the public to make informed choice of practitioner appropriate for themselves. This also better enables determination of whether or not a practitioner has provided the service they proclaim to do. By accepting and focusing on the core aspects of health care we empower all: health care workers to provide the service they believe in and the public to receive the service they want. Thus this approach is part of the first suggested step of educating the public on how to select the appropriate practitioner for them, a critical step in empowering the public.

III Integrity of practice

Grant's (2003b) focus on the underpinning principles of the practice and how to maintain philosophical integrity whilst addressing the demands and needs put upon the practitioners of CAM is a critical point for developing CAM occupations. For if they choose to follow the demands of the orthodox system then they will fail to respond to the demand of the people. Consequently it is important for CAM practices to stay true to the principle of the occupation whilst establishing effectiveness where appropriate. To do this it is important for holistic CAM practices to be clear of the different aspects of practice and whilst developing the analytic aspects of their practice maintain integrity with the whole practice. This approach would avoid the over focus of analytic practice and research with its disregard for human spirit.

If the assertion is that health is not purely physical and quantitative in nature then there is no need to attempt to assess it in purely physical, quantitative measures. Rather it is important to be clear about what is and is not suitable for the 'modern' approach to research and why. This perspective enables CAM practices to embrace analytic research for the aspects of the practice that are analytic, at the same time holistic practice need to be

clear and articulate of how they are holistic. By being clear and articulate holistic practices will be better able to avoid being dragged into an analytic standardised approach when it is not appropriate for the practice.

Alternatively the dominant health care system could increase the use of holistic principles by being open to multiple realities, the human spirit, humane caring, empowering their clients by promoting genuine choice and respecting their choice. This could be supported by education in the different aspects of the holistic approach so that the practitioner can recognise where they do use holistic principles and ways they could develop greater holistic practices, if they wanted. By understanding the importance of the human spirit biomedical practices could enhance the use of humane caring and once again see its value. By gaining greater knowledge on CAM practices biomedical practitioners could support the provision of accurate information and empower choice. Client's demanding choice may be seen as a threat to the authoritative approach of biomedicine, however by shifting the focus to one of compassionate service choice would no longer be a threat.

Summary

To deal with the social crisis that is currently occurring in the health care system it is necessary to resolve the felt dissatisfaction that is driving the crisis. It is presented that the public felt dissatisfaction that is driving the increase of CAM is due to the desire for a humane and respectful service that empowers individuals, recognising the multiple approaches to health and the right of choice in health care. As a consequence what is needed is a system that reinforces informed choice and awareness that there are viable options without bias. That is with understanding and acceptance of different views on what is appropriate health care.

To support this change of 'putting the heart back into health care' and the creation of an enlightened health care service, it would be of benefit for the value of each approach to health care be mutual recognised and appreciated and then for education in health care to cover the two approaches. This would enable practitioners to understand and articulate how they work in relation to them. To support choice in selection of an appropriate health care

practitioner it is recommended that practitioners clarify and articulate the basis of their practice and that this information is provided to potential clients, where practical.

Conclusion

*In our wild rush over the past few hundred years for what
we now consider to be rational and scientific
we have lost so much which has been
known and valued for thousands of years and
which is vital to our survival as human beings.*

Erskine, 2006; 258

This thesis set out to consider the professionalisation of aromatherapy practice as a case study for the development of CAM modalities in the Australian health care system. As such the context of CAM occupations potential development was reviewed and in doing so it was noted that currently the Australian health care system is experiencing a ‘social crisis’ due to the persistent increase in demand for CAM practices. Within this social crisis the felt dissatisfaction of aromatherapy practitioners emerged to be due to the false belief that aromatherapy practice is a profession, the lack of recognition for the therapeutic value of the practice and to a perceived double bind with regard to research for the practice’s knowledge development and maintenance of the practice’s ‘essence’.

Due to the belief in aromatherapy practice and its potential contribution in health care, by participants, pathways for the occupations development were examined. Four pathways for the professionalisation of aromatherapy practice were outlined however it was determined that the occupation has only one effective choice in regards to professionalisation. This is because aromatherapy practice’s knowledge base is significantly less than is required for a profession and while a potential pathway is there for the development of an appropriate knowledge base the time and resources required for its development ensures its impracticality.

A further critical issue is that to become a true profession, with statutory regulation, a significant ‘risk’ must be demonstrated requiring the state to act in order to protect the public. As aromatherapy practice is promoted to be and accepted as a relatively safe practice this criterion is not fulfilled. Aromatherapy practice as a true profession is a very unlikely outcome. However aromatherapy practice could professionalise in order to set standards and control who may be a registered practitioner.

Two other potential pathways for the occupation’s development were considered; development as individual practitioners and integration within other health care practices. It is presented that the most likely pathway for the practice of aromatherapy to develop within the Australia health care system is by its integration into nursing practice. This is because of a philosophical match between aromatherapy and nursing practice, nursing interest and nursing’s available resources to develop aromatherapy practice.

However in order to deal effectively with the felt dissatisfaction of aromatherapy practitioners it emerged that it is necessary to, either individually or as an occupation, accept the practice's current status in the health care services and deal with the practice's identity crisis. Dealing with the identity crisis can be achieved by clarifying the practice's service and underpinning principles. This would support gaining recognition by providing a valued service. This approach to the occupation's development changes the focus from becoming a profession to establishing and promoting a valued service, by contributing to society. This approach also allows individual practitioners to develop their own practice regardless of the occupations development.

Significantly another source of felt dissatisfaction emerged as part of the course of the study, along with a second false consciousness. It emerged that the drive for CAM services is due to the public felt dissatisfaction with the service provided by biomedical health care. With the public pushing for a more humane health care service, one that supports the individual's right of choice and ability to enhance their quality of life. There is indication that a significant number of members of the public want principles of holistic practice in health care. This drive is indicated to be associated with a more general social change related to an increased post modern view that questions and challenges authority.

The current attempt by the biomedical profession to deal with the social crisis demands that CAM practices meet biomedical standards and is based in the belief that biomedicine's physical modern analytic approach with a 'right' intervention is the only 'right' way. This attempt assumes that the public too are looking for the 'right' intervention. This is seen to be a false consciousness as the public appear to be demanding more than what biomedical practice traditionally provides. Consequently this attempt to establish the right intervention does not respond to the public's felt dissatisfaction and thus will not resolve the social crisis. As a consequence the demand for CAM is likely to continue, as long as CAM is seen to provide the service the public is asking for. Further any attempt to ensure holistic practices meets the standards of analytic demands puts the integrity of holistic practice at risk. Unlike pure analytic practices holistic practices value the unpredictable quality of the human spirit.

The value of the human spirit in health care is increasingly being demonstrated and it is argued that CAM practices ought not 'give up' nor 'give in' but rather see and

remain true to the value in their practice. It is in the interest of CAM modalities to remain true to the principles of holism in order to provide the public with what it demands. However to establish credibility the development of scientific knowledge is required. In order to do this and maintain integrity with the principles of holism it is important to recognise the multi paradigmic approach to scientific research and that the analytic approach is an aspect of the holistic practice. This allows for appropriate practice related research and addresses the perceived double bind between knowledge development and maintaining the 'essence' of the practice.

It is suggested that in order to deal with the public felt dissatisfaction effectively the issue becomes one of recognition of the value of each approach to health care and the development of an enlightened health care service that 'puts the heart back into health care' in a professional safe and effective manner. It is suggested that both biomedicine and developing CAM occupations consider their role and contribute to the system in order to improve it. This requires that their underpinning principles, the philosophies of each approach be clearly articulate and shared. A true social change would be the effective integration of holistic principles into the system.

An extension of this development is the promotion of the right of choice and empowerment by the provision of information to enable informed choice in health care, which includes information on how to select a practitioner in health care. To complement this it would be of great value for individual practitioners to provide information on their approach to health care and thus the service they provide. These steps support health care which respects individual preferences and the right to live as one chooses, with the letting go of the idea that the expert knows better than the client what is right for them while promoting respect for the advance and systematic knowledge base that the expert practitioner has to offer, not to mention experience. This process has the potential of developing an enlightened health care system that is responsive to the public's needs in a safe and efficient manner.

A framework to support the process of social change is recognising that analytic health care is an aspect of holistic health care. This framework enables analytic research for the aspect of CAM that are analytic in nature and yet also supports post modern research for the aspects of holistic health care that are not analytic in nature.

The basic principles of the framework are: distinguishing between the modern and post modern aspects of health care; seeing the value in both aspects; and acknowledging it is NOT a matter of holistic integrating with biomedicine, but rather recognising analytic practice is a part of a holistic practice. Thus the need for integration rather than revolution, the pendulum has swung from one extreme to the other it is now time for it to settle in the middle as best it can.

How to provide this service whilst dealing with the need to secure an income is also an important consideration. The recommended first step of clarifying and declaring the principles of each individual practice to assist with the issue of service verse business is only a small step in the matter. For other ethical issues of health care practice must also be dealt with. Not least the trust that is still required for it is still necessary to trust that the expert does provide the information in the consumer's best interest. Further there is no doubt that safety issues would take precedence and that the vulnerable would still require greater support.

This study's contribution is on two primary levels: firstly the intention to provide critical arguments that could provide guidelines for the development of aromatherapy practice and other CAM. This has been achieved by providing alternative pathways for occupational development and outlining the requirements for each pathway, as outlined in Chapter Eleven. These critical arguments can be incorporated by any CAM practice considering its professionalisation or development. Secondly the clarification and articulation of the need for the two broad approaches to health care, analytic and holistic, in order to gain greater clarity of the underpinning philosophy of each and determine how they may best work together so they may provide a service for the public that meets the public's demands. In this way the potential to resolve the public's felt dissatisfaction whilst endeavouring to provide a safe and effective health care service is proposed.

Whilst the study has revealed and suggested apparently plausible suggestions for the future development it is necessary to remember that it is based on the researcher having stood apart from the prevailing world order and ask how the situation came about (Cox in Fontana, 2004). This reflection on patterns of thought and action was in order to challenge institutionalised power relations and provide an alternative conception of self and the

motivation to change (Fay, 1987). Thus whilst the critical theory is based on insights obtained from literature and participants it is important to remember that it is also based on insights of the researcher. Critical theory has been criticised for a tendency toward elitism (Clark, 2003) in that the researcher assumes they know best. In this study the researcher is not promoted as an expert on what ought to be done, rather as having the expertise to analyse the situation and has taken the opportunity to do so. Consequently this critical theory may be rejected and what remains to be done relates to whether this critical theory with its proposed arguments has 'grab' for the occupations and health care system that it targets.

Beyond this underpinning limitation there are limitations at each level of critical theory development which need to be considered. Occupational development was the focus of the study and has at least three core limitations that must be considered. Firstly the issues of the potential bias due the small sample size combined with the self selecting non participating aromatherapist group must be considered. The small sample size used as part of the grounded theory sampling to saturation fits the methodological approach and demonstrates the issues discussed. However it is possible that further issues may have been revealed with a larger more inclusive sample, specifically if the self selecting non participating group was also represented. What impact this has on the potential influence of the occupation is not able to be determined and thus has the potential to limit the applicability of the theory for the occupation.

Another issue relates to the issue of the use of aromatherapy as a case study for wider CAM practices. The development of the critical theory specifically focused on aromatherapy practice and the 'fit' of the theory, its relevance, to other CAM occupations depends on how well the issues match the specific occupations. Obviously such issues as the identity crisis may not be relevant, however all the occupations must deal with the regulations and policies of the Australian health care and government and it is on these broader issues that the fit depends.

In regards to the development of the health care system and the recommendation of recognising the value of the analytic and holistic health care approach is limited by the possibility that biomedical practice and indeed other dominant players, such as the government, agree with the asserted value and possibility for this integration. Further

limitations for this aspect of the study are that even if the critical theory has appeal and grab such that it motivates action the study has only very broadly considered the matter related to the philosophical educational aspect with barely a mention of the ethical issues that would need to be addressed. Consequently it has simply opened a vast field with significant ramifications that go well beyond the realm of this thesis and thus present limitations of the study.

Over all the study found the process of change is underpinned by the transition of the society from a 'modern society' that disregarded the human spirit, to a 'post modern society' that values the human spirit. The shift is seen in other areas of society and the study included a brief discussion on the need for a new model for a 'profession for the 21st century' suggesting a 'contemporary profession'. This brings us back to the focus for the study the professionalisation of aromatherapy practice as a case study of the development of CAM in the Australian health care system which highlights a call for 'returning the heart to health care.'

Appendix 1

Interview Guide

Professionalisation of Aromatherapy Interview Data Sheet

Date:

Participant number:

Occupation:

Age:

Gender:

Training in Aromatherapy:

Use of aromatherapy:

Key Question:

Aromatherapy appears to be a growing force in Australian Health Care. What are your thoughts on this development?

Themes:

Aromatherapy- what is it?

Methods of application

Framework/holistic

Aromatherapy as a profession

Ideal /Service to society

Knowledge base

Education Standards

Autonomy/Registration

Risk/Safety

Ideal future/ Challenges

Appendix 2

Informed Consent

Introduction Letter

Janelle Sheen
BSc, BA, MSc, MAAMA,
PhD Student
Southern Cross University
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03 95856952

To Potential Participants of Professionalisation of Aromatherapy Study

As part of my doctoral studies at Southern Cross University, I am researching aromatherapy as a profession in health care. I am investigating how aromatherapy is perceived by different groups of society. This includes its perceived service to society, how it fits into the current health care scene, and how it is viewed as a profession.

I am seeking individuals who would be willing to commit approximately one and one half hours to the study. In this time we will discuss their perception of aromatherapy as they relate to the themes outlined above. All data collected will be confidential and will only be used for this study. It is planned to publish the findings and present them at conferences. Anonymity is assured for all participants in any publication or presentation arising from the study. On request, the results can be forwarded to participants.

While participation may not provide any direct benefit to participants, it is hoped that the study will provide valuable information on the professionalisation of aromatherapy in Australia. The information may have an important impact on how aromatherapy is integrated into Australian health care. Thus, participation has the potential to impact on aromatherapy in Australian health care.

Participation in the study is voluntary and if you choose to participate, you have the right to withdraw at any time.

If you wish to participate, could you please contact me on the above phone number or email address.

I have enclosed information that gives more details about the study for your perusal.

Kindest Regards

Janelle Sheen

Information Sheet
The Professionalisation of Aromatherapy

Principal Researcher: Janelle Sheen
Associate Researcher/Supervisor: Dr. John Stevens.

You are invited to participate in a study on aromatherapy as a health care profession. We hope the study will enable us to determine how people perceive aromatherapy and how it is believed to fit into current health care practice, in Australia. The results will provide 'reality-based' information about current perceptions of aromatherapy in Australia. We hope this will develop a greater understanding of aromatherapy, how it fits into Australian health care, and how it is perceived as a profession. Further, we hope to glean valuable information that can inform aromatherapy education providers about training needs and curriculum content and thus the development of aromatherapy in Australia.

Participation in the study is voluntary. If you choose to participate, you will be involved in an interview with the primary researcher that will be no more than one hour in duration. The purpose of the interview is to explore your perception of 'aromatherapy', the service it provides to society, how it fits into health care and in particular, how it is viewed as a profession. The interview will be audio taped. After the data has been analysed, the findings in which your data has been included, will be forwarded to you for feedback. This is to ensure the findings do reflect your perceptions. You may not receive the findings until some weeks after the initial interview. It is estimated that the study will require no more than one and one half hours of your time. There are no risks to participants in this study. The only inconvenience is the time commitment.

It is the researchers responsibility to organise a suitable time and place for the interview, to forward the feed back to you and to provide a means for the feed back to be returned to the researcher. It is important to note that all information provided will be kept confidential. All data, including the audio tapes, will be kept securely in a locked drawer in the researcher's study. Only the researchers involved in the study will have access to the drawer. The collected data will only be seen by the researchers conducting this study and it will only be used for the purposed outlined here. All data will be kept for five years and then destroyed. Further, you will not be named or identifiable in the findings, nor any publications or presentations resulting from the study. These steps are in line with the *Privacy Acts*, 1988.

It is important that you inform the researcher about any aromatherapy training you may have undertaken and any aromatherapy practice you may perform, as well as your occupation if you are trained or practicing as a health professional, .e.g. you are a doctor, nurse or naturopath. We need this information in order to determine any differences in perception between the various occupations and levels of training.

If you decide to participate, you are free to withdraw your consent and any unprocessed data at any time. However, if you do decide to withdraw we would appreciate you telling us as soon as possible.

If you have any questions please feel free to ask them.
Dr John Stevens or I are happy to answer any questions or address any issues you may have about the study, at any time. Our contact details are:

Janelle Sheen Southern Cross University
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PO Box 157
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03 95856952

Dr John Stevens Southern Cross University
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jstevens@scu.edu.au
02 66203306

If you have any issues or complaints regarding this project that cannot be answered by myself or Dr, John Stevens then please contact:

Mr John Russell Southern Cross University
Ethics Complaints Officer

Graduate Research College,
jrussell@scu.edu.au
(02) 66203705
Fax: (02) 66269145

Please keep this form for your use.

Sincerely

Janelle Sheen

Informed Consent Form

Professionalisation of Aromatherapy

I have read and been given a copy of the information sheet about the study entitled: 'Professionalisation of Aromatherapy', and agree to take part in the study. I am 18 years or older. I understand my participation is voluntary and that I may withdraw at anytime.

My name is

Signature Date

Witnessed by
(must be independent of the study)

Signature..... Date

I certify that the terms of the study have been verbally explained to the participant and that they are competent to give consent and appeared to understand what is required prior to signing this form. I also, certify that proper arrangements have been made for an interpreter where English is not the participant's first language. I have given the participant the opportunity to discuss the project with an independent person before signing.

Researcher

Signature Dated

Abbreviations

AAMA	Australia Aromatic medicine Association
ACNEM	Australasian College of Nutritional and Environmental Medicine
AIMA	Australasian Integrative Medicine Association
AF	Anomous Feedback
AHP	Association for Humanistic Psychology
AMA	Australian Medical Association
AQF	Australian Qualifications Framework
ATO	Australian Taxation Office
CAM	Complementary and Alternative Medicine
COAG	Council of Australian Government
CSHISC	Community Services and Health Industry Skills Council
CSU	Charles Sturt University
EBM	Evidence Based Medicine
IFA	International Federation of Aromatherapy
IFPA	International Federation of Professional Aromatherapists
IJA	International Journal of Aromatherapy
RACGP	Royal Australian College of General Practitioners
RSA	The Royal Society for encouragement of Arts, Manufactures & Commerce
SCU	Southern Cross University
TAFE	Training and Further Education
TCM	Traditional Chinese Medicine
UNE	University of New England

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