

# How can you make a career as a complementary therapist?



# Putting embodied knowledge into practice: a follow-up study of graduates from complementary and alternative medicine training courses

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## Summary and Key Messages

This research study, carried out by Dr Nicola Gale at the University of Birmingham, set out to understand how osteopaths and homeopaths were able to build a personally and financially sustainable career as a health practitioner. Complementary and alternative medicine (CAM) retains a small but enduring position in most healthcare systems. Researchers have looked in depth at why patients choose CAM, but much less is known about the practitioners of CAM, such as their aspirations and their experiences. In the absence of the established careers paths that are seen in other healthcare professions (such as nursing, midwifery or medicine), the study sought to understand how new graduates managed the transition to practice, built their professional networks and were able to build a successful practice.

This report is primarily designed for practitioners, educational institutions and professional groups in CAM. It provides a description of the data collected for the study and explains the four key messages that are most relevant for the profession.

## **1) Acknowledge that there is a transition phase**

Many graduates assumed that the biggest hurdle was getting their qualification to practise and that once they had it they would be able to build a busy practice. However, they found that in reality, there was a lot more to learn and that it could take many months or years to achieve the idea of a 'successful' practice they had hoped for. The biggest challenge in this phase was to understand that being in practice is also about building a business. Most CAM is practised independently in the private sector; therefore, most practitioners were self-employed and there were few 'jobs' available. Most saw this as a benefit of their choice of career, giving them independence in their working life. Nonetheless, the early phase of building any new business is extremely hard work and required a number of financial, marketing and communication skills.

Most graduates felt well prepared from their education for the technical and communicative aspects of practice (i.e. what happens *in* the consultation room), but poorly prepared for the business aspects (i.e. what happens *outside* the consultation room). Other creative and vocational careers, such as art, film and fashion, now strongly encourage and support students to engage with business at undergraduate level, for instance, through development of a portfolio or engagement with new social media. At the dissemination event for the study, some educational institutions recognised that this was a significant gap in their curriculum and made commitments to improve this.

## **2) Reflect on your professional identity**

Many CAM practitioners consider their career as vocational. They have usually had positive experiences of the therapy they are training in and want to be able to help others. As such, after completion of training their primary professional identity is '*being a health practitioner*'. For some this is sufficient, and they will continue to make use of other sources of financial support to ensure that they can offer their services on a part-time basis or at low cost. However, for others who want to make CAM their full-time career, they see their primary identity as '*being a person who makes a living out of being a health practitioner*'. Generally, there is a flat career structure in CAM, i.e. you are either a qualified practitioner or not. However, some practitioners seek ways to 'progress' their career and see their primary professional identity as '*being a person who influences the wider health field*', for instance through teaching or mentoring junior colleagues, conducting research, or writing and publishing.

New graduates should reflect on what they are looking for in their career – their personal goals and attributes, as well as the context they are operating in. Both of these will change over time and it is useful to start thinking during training, but to revisit at key points during their career.

### ***3) Get the support you need***

Being an independent practitioner can be isolating, so practitioners found that seeking support is vital to building a personally and financially sustainable practice. New graduates who were successful in building their practice found support in a variety of ways. They often got practical and emotional support from friends and family. They got support for developing their knowledge from professional groups – both online and in person – or from discussions with and observation of close working colleagues. Crucially, they received support from just a few ‘like-minded’ people who enabled them to think critically and reflectively about their practice.

One way for practitioners to think through this is to draw a map of their own support networks, using the following process: Put yourself in the middle of blank sheet of paper and put friends, family and colleagues on the map. Draw lines to them with arrows of different sizes to indicate support flowing through the map. Which of these links are ‘sustaining’ for you? Are you making an effort to cultivate the connections with people who may have insights for your career? Where are your gaps? New graduates from other health professions often have a mentor or supervisor in the early years of practice. CAM practitioners could use a mentor relationship to develop clinical practice, or business skills, or both.

### ***4) Contribute to your community of practice***

A community of practice is when a group of people come together over an extended period of time to undertake collective learning and development. They support one another through coordinated efforts to solve problems and to develop their knowledge as a group. Nurturing these communities of practice can be extremely positive for the quality and safety of care given. Communities of practice in healthcare often form around specific places, such as a hospital ward or a general practice. Although some osteopaths and homeopaths described their practice as inherently isolating because of working alone, they also described ways in which they were able to participate in communities of practice, both at a local level through multi-therapy clinics or peer mentoring groups, or at a profession-wide level through professional associations and journals.

There are ways in which individual practitioners can nurture a community of practice, such as focusing on a particular specialism, through postgraduate courses and special interest groups. New graduates could actively seek a clinic to work in that had good support in place for practitioners, through an associate/apprentice relationship to a principal practitioner, or through team meetings. Professional associations and educational institutions can also do more to develop an environment that is conducive to community activities and group learning.

## Why is a sociologist interested in complementary and alternative medicine?

Dr Nicola Gale is a health sociologist, based at the University of Birmingham



Sociology is the study of society and covers everything from the everyday social interactions between individuals, to the dynamics of communities, to large scale social trends. The use of complementary and alternative medicine (CAM) is a major social phenomenon, and a controversial one, making it a fascinating topic for sociologists.

The following definition of CAM from the [Cochrane Collaboration](#) highlights the socio-political nature of CAM:

‘Complementary and alternative medicine (CAM) is a broad domain of healing resources that encompasses all health systems, modalities, and practices and their accompanying theories and beliefs, *other than those intrinsic to the politically dominant health system of a particular society or culture in a given historical period*. CAM includes all such practices and ideas self-defined by their users as preventing or treating illness or promoting health and well-being. Boundaries within CAM and between the CAM domain and that of the dominant system are not always sharp or fixed.’ (Zollman and Vickers 1999, *emphasis added*)

As part of the research project, I reviewed the last 15 years of sociological research on CAM, which was published in [Sociology Compass](#). A video introducing the article can be found [here](#). Sociologists have studied three main aspects of CAM:

- *The ‘people’* – research with users and practitioners of CAM
- *The ‘big picture’* – the social trends influencing the use and practice of CAM
- *The ‘big question’* – how CAM works

## The people

The evidence suggests that most people who use CAM use it alongside any conventional medical treatment that they are receiving. There are a series of reasons that ‘push’ them away from conventional medicine, such as dissatisfaction with the doctor-patient relationship and concern about side-effects or surgery. There are also reasons that ‘pull’ them towards CAM, such as recommendations from friends with positive experiences, a preference for the time and individualised care received as part of a CAM consultation, or a philosophy of holism and nature. The pull factors are what keep users coming back over time.

There have been a number of studies that have looked at the general process of professionalising of CAM practitioners, and the legal frameworks of regulation in which they operate. However, we know a lot less about the practitioners of CAM, such as why they choose their careers, their education, and their professional communities.

## The big picture

It is popular to say that we live in a ‘pluralist’ world of healthcare – that there are many different types of treatment available and that the consumer of healthcare can choose between the options that they consider most appropriate for them. However, conventional medicine, informed by Western biomedical science, is still the dominant form of medicine, supported by the state and by large scale industries, such as pharmaceuticals. ‘Other’ types of medicine, both indigenous forms of medicine and alternative therapies, are usually seen as sub-ordinate and marginal.

Over the last few decades, particularly in Western countries, there have been calls for the ‘integration’ of conventional and complementary medicine, i.e. to take the best of all the different systems in the interests of the best possible care for the patient. Some of these integrative practices have been remarkably positive for patients, who experience it as empowering to have many types of treatment available in one place. However, in practice, conventional doctors tend to retain their dominant position in these kinds of integrative practices and the effect has sometimes been to try and make CAM more like conventional medicine, rather than to embrace its differences.

Taking a more global perspective, some scholars have explored the notion of ‘hybrid’ medicine that challenges some of the assumptions about the inherent value and superiority of Western biomedical science. These studies have looked at the ways in which medicine is used in different ways, in different places and by different groups of people.

Finally, there is recognition that for some, their use of CAM is a form of activism. They can resist the dominance of conventional medicine and its associated industries, and use treatments they consider to be, for instance, more natural or more empowering.

## The big question

The first thing that sociologists have done is to ask *who* is entitled to answer the question, 'Does it work?' Some have claimed that the question can only be answered through careful observation of objective clinical measures, while others have proposed that patients are best placed to judge whether or not a treatment has had a positive influence on their lives. Some scientists have claimed that they are the only ones able to answer that question, through scientific study, but others argue that it is more complicated than that because healing is not only a biological process but also a psychological, emotional, social and spiritual process, and that conventional scientists do not have the tools to measure all those things effectively.

Sociologists have tended to focus on *how* treatments work, and particularly on the interaction between patient and practitioner and the experience of the treatment. It is popular to suggest that CAM treatments are just placebo, but there is no 'just' about placebo. If human social interactions are able to effect improvements in health, so much so that they have to be controlled for in clinical scientific studies, then they require further study and a better understanding of the interrelationship of the body and society.

## Aim of the study

In this study, I wanted to focus on the practitioners of CAM, which is an under-researched area in sociology. I have previously studied the experiences of osteopaths and homeopaths who were training for practice<sup>1</sup>. Anecdotally, I had heard that graduates from these courses had varying experiences of setting up practice and, while some had built successful practices, others had struggled or given up altogether. In this study, I aimed to find the answer to the question:

*'How do osteopaths and homeopaths negotiate building a career that is personally and financially sustainable, and continue to develop their knowledge and skills?'*

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<sup>1</sup> Gale, NK (2007) [\*Knowing the Body and Embodying Knowledge: an ethnography of student practitioner experiences in osteopathy and homeopathy\*](#). PhD Thesis: University of Warwick.



## What did the study involve?

The first step involved getting back in contact with the graduates from the colleges that had been involved in the previous study of the education process. The osteopathy college sent letters to their graduates and the homeopathy college sent an email, both including the detail of my study. I received 58 responses, of which 56 completed a screening questionnaire, and 17 agreed to be contacted further. 14 practitioners (8 osteopaths and 6 homeopaths) with a range of experiences of practice and with between 2-7 years post-graduation experience agreed to participate in an in-depth interview. The interview covered the reasons they decided to train, their experience of their professional education, what happened after they graduated and how they managed to develop and grow their practice. I then asked them to describe the sources of support they had for their practice. In addition, I observed 3 osteopaths and 3 homeopaths practising in their clinics, to understand more about the development of expertise in practice. I analysed the data I had collected to identify themes, and 12 months later went back to interview 5 of the participants again to ask for their reflections on my emerging findings, to clarify certain aspects of the data and to explore others in more detail. Throughout this report I have used pseudonyms to ensure that all participants can remain anonymous.

## What did I discover?

There are two major findings in the study. The first is related to how practitioners were able (or not) to make a successful career from their practice. The second explores the ways in which practitioners built networks of support for their practice. These will now be explored in more depth and illustrated with data from the study.

### [1] Making a career from CAM practice

#### Why did they start?

Many embark on training as a CAM practitioner as a second career. Previous careers of participants were wide ranging and included police officer, actor, musician, researcher, chemical engineer and IT consultant. Only one of the participants in the study had decided to study osteopathy directly after completing a first degree in sports science without doing another job first. All had personally experienced positive responses to the treatments that they subsequently trained in. This is unsurprising because careers in CAM are not the kind of thing you learn about as a child, unlike being a 'doctor', 'nurse' or 'midwife', so personal experience is the only way you would have an idea of what the occupation might entail. As Susanna explained, she didn't know what osteopathy was until she by coincidence has some treatment:

*I met these guys, and they were in their third year, and one had just qualified... obviously windsurfing holidays are active, hurt my neck, and this guy said, 'Oh, I'll give you a bit of treatment,' and I thought, 'Great wow that was amazing.' You know when you just, sort of, yank it and it's really sore, and I was, like, wow, that was brilliant. I want to be able to do that. So, I got home and I thought, right, I'm gonna look into this. (Susanna, osteopath)*

In 2005, two sociologists, Lisa Mainiero and Sherry Sullivan, explored the phenomenon of women who actively chose not to aspire to traditional careers in hierarchical organisations, even when they were very capable of doing so. They developed the concept of 'kaleidoscope careers' to show how people's priorities with their career can change over the life course, like the kaleidoscope that changes colours and patterns as you turn it around. The three main areas that they found that people aspired to were *authenticity*, *balance* and *challenge*. This is useful for understanding why people choose a career in CAM and how their priorities can change throughout that career. There are some intrinsic forms of motivation for CAM work both ethically and intellectually, but there are other social and family responsibilities and interests that are important too. For many of the homeopaths and osteopaths in this study, *authenticity* was key to their decision:

*'I don't know, it's just kind of being led to it over the years, so a calling really and you can either listen to that voice in your head or you can block it out and I chose to listen to it, I suppose.'* (Erika, homeopath)

Lesley saw the decision as a good way to find *balance* in her working life as she approached retirement:

*'Erm, and so – and just sitting with this homeopath one day, and watching him work, and, and I, I thought, 'Well,' you know, 'I could do that, and I, I would be really interested in doing it. And if,' you know, 'if I could help other people in the way that he has helped me, that would be a really good way, you know, to spend', I dunno, the rest of my working career'* (Lesley, homeopath).

Susanna was also driven by her preferences for independent working conditions:

*I just thought there's so much bureaucracy and I just felt that I wanted to be in control of the hours I do, where I work, and I thought, 'you can't get that in the NHS' and, also, that, you know, I don't have that bureaucracy. I mean, there is obviously some with osteopathy, but not in the same way, I don't think. I mean, I don't know, because I've not worked for the NHS, but that was my thinking at the time... I always saw it as a way to have a family but work and actually I'm really pleased now that I've done that. (Susanna, osteopath)*

## What did training involve?

All the participants had learned knowledge essential for practice during their basic professional training and this was evidenced by their qualification and their ability to register with an appropriate regulatory or registering body (in the case of the osteopaths, the General Osteopathic Council).

- Cognitive knowledge (of the body in health/illness, of treatment principles)
- Emotional knowledge (of the self and reflective practice)
- Communicative knowledge (of working with others, talking to patients)<sup>2</sup>
- Embodied knowledge of assessment and treatment<sup>3</sup>

The training experience has been reported in detail elsewhere<sup>4</sup> but in this study, I asked participants to reflect on their training and how well it had prepared them for practice. While in many other parts of my participants' narratives, there were great similarities, there were marked differences in the accounts of the training process between the osteopaths and the homeopaths. This reflected different philosophical, practical and pedagogic differences in the structure and management of the courses. The primary difference between the narratives was that the osteopaths generally described it as story of achievement, of conquering the course, whereas the homeopaths described the course as transformational.

All the osteopaths agreed that it was a hard and often stressful course:

*I really enjoyed it but it was quite stressful [laughs], especially by the end, it was just so intense. Yeah, I think you've got to be pretty dedicated, and quite a few people dropped out along the way, which I think is completely normal, and I can understand it. I just kept in mind that, you know, I've come so far I may as well carry on and also you've kind of got this idea that at the end you were gonna have well a job hopefully, that you could make what you wanted from it which is what kept me going (Susanna)*

For some their particular challenge was the first year of the course which was theoretical in focus and the book learning was difficult having been out of education for some years. Even those with a previous degree found that it was an intense period of learning that was challenging. For others, they found that the shift to the student clinic and learning about the practical skills of interacting with patients was difficult. Lois described feeling 'saturated... input, learning, time restraints, deadlines, objectives, pressured'. However, all concluded that they had learnt the vital basics of being an osteopath.

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<sup>2</sup> Gale, NK (2008) '[Promoting patient-practitioner partnership in clinical training: a critical evaluation](#)', *Learning in Health and Social Care*, 8(1): 13–21.

<sup>3</sup> Gale NK (2011) '[From body-talk to body-stories: educating for body work in complementary and alternative medicine](#)', *Sociology Of Health And Illness Special Edition/Monograph, Body Work in Health and Social Care: Critical Themes, Future Agendas*, 33(2): 237–251.

<sup>4</sup> Gale, NK (2007) [Knowing the Body and Embodying Knowledge: an ethnography of student practitioner experiences in osteopathy and homeopathy](#). PhD Thesis: University of Warwick.

The uniqueness of the homeopathy college was recognised, even within the homeopathy field generally; it was, one participant put it, 'a whacky college' (Erika). The kinds of language and concepts used were not familiar to all who started the course:

*'part of me felt very self-conscious about the kind of approach at the College where it was quite sort of you know they were talking about things like intuition and they were talking about things like the power of intention and, whereas up until that point I'd done my own sort of studying to homeopathy and I had been using it for myself, I'd had a repertory and you cross-reference remedies, you came out of a remedy and you gave one remedy and that was it and then they yeah they seemed, it was very eclectic and there seemed to be lots of different ways in and lots of different approaches and in some ways in a sense everything goes if it works that sort of thing whereas I wanted a clear way a clear direction of this is how you do it and you go out and do that. But something must have drawn me to studying in that way because I could have had more of that had I gone to one of the other schools'. (Mark)*

What came out was how different the learning experience was – it was about self-development as a practitioner – and a person – rather than about acquiring facts:

*'the actual cold, hard cash of knowledge of remedies and of how to look things up and the process of healing and all the you know the material medica and all the homeopathic theories of process of the healing and the miasms and all that shebang but that's all theory isn't it, that all just knowledge, that's just theory you can learn that anywhere but what none of it can teach you and I think certainly, well, that's what I learned at [college] was the confidence to trust that it's ok I suppose, I mean, it can be really scary when you sit with somebody like [Patient] who has panic attacks after panic attacks ... the most horrendous experiences, she has had a terrible life and you know life is very dark, I've had people who are suicidal, people are you know, people that can barely hang together you know really awful, awful lives that people have and I suppose yeah just confidence, faith, trust that I am the right person they are here for a reason, that I can't, that I will do it right'. (Erika).*

Crucial to this was learning about yourself and this could have radical effects on the student's life that enhanced their own sense of authenticity. Mark, quoted above, felt that his training alienated him so much from his previous career in the chemical industry that he could no longer work there and so took a new job as a teaching assistant and Erika explained that 'I got divorced because I became so much of who I really am that we just didn't fit anymore'. In a pedagogic model that focuses so strongly on the interactional aspects of practice – how to listen and be with another person in their distress – the personal and the professional are inescapably entwined.

However, both the osteopaths and the homeopaths felt that there was a big leap from training to practice.

## What happened after they graduated?

Of the practitioners who took part in the in-depth interviews, three were no longer practising, seven had made a partial transition to practice and four were established practitioners. By analysing their accounts I discovered that those that had become established had a combination of *knowledge* that they had acquired at college and continued to develop, *passion* for the therapy itself and of working in practice, and a capacity for *enterprise* to set up a small business around their practice. Finally, some had begun to think through ways in which they could progress in their career, through developing a sense of *wider purpose*. See Figure 1 for a summary of these findings:

Career Outcome	Components
Disengagement	Knowledge
Partial transition	Knowledge + Passion
Established practitioner	Knowledge + Passion + Enterprise
Progression	Knowledge + Passion + Enterprise + Wider purpose

Figure 1: Requirements for career progression

### Disillusionment and disengagement

During training, students were around like-minded people and graduation, as well as being an achievement, also signalled the end of that community. The re-integration in the wider social environment without the buffer of the college was a difficult transition for some, who found themselves disillusioned or disengaged. Reasons included experiencing antipathy from others in the community about their choice of profession, lack of support from colleagues, difficulties in finding clients, being unable to find a job, and no longer having a strong commitment to the therapy.

**Daniel**, who trained as an osteopath after taking early retirement from a career as an IT consultant, found that his belief in osteopathy waned during the course:

*'as the course progressed, to me it became less scientific and more osteopathic... I suppose my belief in osteopathy wasn't that strong, I'm a bit more cynical... In retrospect, I should have just given up after the first year, but at that time I was reasonably happy'...*

Overall, he felt that he had benefited personally from the course:

*'I gained a lot from having done the course which I wouldn't like to now not have... I've learned about ageing, which I think is going to help me and my wife in later age... the importance of keeping mobile... I've completely changed the way I eat and my beliefs on food'.*

After graduation, he set up a practice at home in Essex and started seeing clients:

*'initially it went reasonably well with the patients, it became harder and harder to find new patients, perhaps something to do with the area I was in... I would have expected more patients... It was very disheartening'...*

However:

*'eventually without making an awful lot, I decide to call it a day and I think I was a lot happier afterwards... Financially, it was a disaster, the amount of savings we've gone through and the lack of earnings.'*

**Cara** trained as an osteopath after deciding to move away from a career in publishing, although she continued to work part-time throughout her training and as she started to set up her practice. She has found her training challenging. While she had excelled in her first degree, gaining a First Class Honours, she found *'analytical and lateral thinking'* came more easily than the *'sheer volume of memory work'* and the *'practical'* aspects of the course that involved *'learning how to handle people'* and which were much more *'challenging'* for her. After graduating, she set up a practice in London working as an associate in a number of different clinics. However, she did not receive any support or mentorship from the principal osteopaths at those clinics:

*'I still believe very strongly in osteopathy, and I have osteopathy myself, but I don't think that I left college actually ready to go into practice on my own, with all the skills I needed and the confidence that you need.'*

Without support, she didn't feel that motivated to continue to develop her practice:

*'Which was one of the reasons why I decided to stop doing it, to be honest, because I don't want to strive for mediocrity. Your knowledge gets rusty... I couldn't motivate myself to address the areas that I knew need to be addressed' (Cara)*

At the time of the interview, she has ceased to practise as an osteopath and was continuing her publishing work while considering what to do next.

**Joshua** trained as a homeopath alongside a career in engineering. He found it to be a personally transformative experience:

*'I'm a telecommunications engineer going to homeopathic college, but [it] allowed me to actually transform myself...I started to get the joy back in life because I was involved in this thing where I could feel some part of me coming alive again... All three years boiled down to one word for me and that was 'trust'... it allowed me to give into something that I had always sensed, that what I really wanted to do with my life was help people and help them to heal... I thought I'd realised at that point that that was my real calling.'*

However, after graduating:

*'I set up my practice and I started seeing patients and it just kind of faded away... then I moved [to Oxfordshire]... then the energy got switched off and I was then focused on finding my life with my partner, which has been another big thing for me... there's this real sense of limbo... I've stopped introducing myself as a practitioner now... I decided to re-train in my day job which has really taken a lot of energy in the last two years... I'm actually learning every day and feeling again like I'm actually doing something worthwhile.'*

He still thinks that he might like to practise, but does not see it as financially viable presently:

*'I kind of imagined this little clinic in [my home country]... in my dreams... If I didn't have to make a living from it, that would take a lot of pressure off.'*

Daniel had become disillusioned with osteopathy and did not want to practise any longer, despite the investment he had made in developing his osteopathic knowledge. While Cara and Joshua still used osteopathy and homeopathy respectively for their own health, it was no longer something they were passionate about doing as a career as so had disengaged.

### Partial transition

Those who were continuing to practise and had made a 'partial transition' retained **passion** for their role as a practitioner. They experienced high level of job satisfaction, but were not (yet) making a living from it. The osteopaths in this group were **Ricky** (who was practising from home and as an associate in two clinics in London), **Susanna** (who worked part-time in a clinic in Hertfordshire) and **Aidan** (who worked from his home in London, at a clinic in a community centre, and for a company that delivered physiotherapy and osteopathy to the NHS). The homeopaths were **Erika** (who ran a clinic from her home in Essex), **Mark** (who worked part-time in a multi-disciplinary clinic in East Anglia), **Lesley** (who ran a clinic from her home in Kent) and **Oliver** (who treats friends and family, while continuing to working full time in his own business in Lancashire).

All relied on other sources of income. For some, this was out of choice. Susanna had prioritised balance in her life and was raising a family. She relies on her partner's income and on support with childcare from parents:

*'Osteopathy is an extremely rewarding career, with high levels of job satisfaction. However, financially almost unviable for 'breadwinners' of the family I think, unless you have the time or means to build a large practice.'* (Susanna)

Oliver had decided only to treat family and friends until he retired and planned to focus on research in homeopathy after that. He said that *'perhaps career is too strong a word, for me it's more of a paid hobby'*.

Aidan and Lesley were both keen to earn a living, but this was balanced with other values and priorities. Aidan prioritised *'social responsibility'* and giving back to the community over income. He often agreed to treat older people and those that could not pay from his local community for free or for very low cost. Before training as an osteopath, he had been a set designer and continued to do a lot of practical *'handyman'* work to earn extra income:

*'I haven't found osteopathy to be a financially rewarding career, although I like treating people and have a number of other jobs to survive... I've got a big account at the bank of good karma.'*

Lesley had specialised in fertility work and often treated local women with low incomes for a much reduced cost:

*'I think if I didn't have other income... an income from a family business. If I didn't have that and my pensions, I, I wouldn't be able to exist on homeopathy alone.'*

For others, they were keen to earn more, but found that their earning capacity was limited. Ricky was earning money from osteopathy, but still reliant on savings from his previous career as a musician and on his partner's income. Mark had given up his previous job as a researcher in the chemical industry. After his training as a homeopath, he no longer felt that he could continue with that work because it did not fit with his changing values. However, he had not yet been able to earn enough from homeopathy, so had taken a job as a teaching assistant, and was also supported by his partner. Erika had also chosen not to continue her previous job, working as a manager in a school, but had started working on a freelance basis for a friend who was a gardener (*'no commitment at all, just got the hourly wage and good fun'*) and took in lodgers, while she worked to build up her homeopathy practice.

A big part of the narrative of the practitioners in the *'partial transition'* stage was on the environment in which they practised, including the physical space, the location and the working conditions. These, they felt, were vital to get right in order to be able to make a living from their practice. The main choices were between working at home, travelling to patients' homes, renting a room in a multi-disciplinary clinic, or working as an associate in a clinic with a principal practitioner. The latter arrangement is common amongst osteopaths, but not homeopaths.

Practitioners often saw renting rooms or working as an associate in a more established practice as a way to attract more clients through the reputation of the organisation



hosting them, or the principal practitioner. However, both had significant financial implications that affected earning potential. Rooms were either rented out on an hourly basis or as a percentage of fees charged to the patient. However, some clinics required the practitioner to commit to a regular slot (such as a half or full day) and to pay rent on that regardless of whether they saw any patients. Principal osteopaths retained 30–60% of each of their associates' patient fee. There were hugely different reports of these associate jobs that ranged from those that took the fee literally just for the room, through to those that got support and mentorship from their principals. Ricky, for instance, had just joined a new practice and felt that the principal there had really supported his development as an osteopath, offering to sit in on his consultations to give feedback and discussing wider issues with him about practice too. This was vastly different from the other clinic he worked at where he simply worked on the days that the principal did not, therefore having little interaction with her. The implications are significant; indeed, Cara had cited the challenges of finding a suitable clinic space as part of her reasons for giving up. She had had to move practice a number of times since she graduated, and felt that:

*'just finding myself having to move and move and move, what that does to your list, it destabilises it, even though I never moved that far... most people are not going to travel.'*

It was also important to some of the participants to find a place that felt authentic. They were concerned that it portrayed the right image to their potential patients, both in terms of location and internal aesthetics. For some, the answer was to create a clinic at home. If working from home, finding the right spatial boundaries for the practice was important. Erika explained that she had a separate entrance and annex for her treatment room, and she had installed a toilet and cloakroom:

*'I just got fed up with people having to go to the loo through the house and that really wasn't working for me or for the rest of the people that live in my house... it's just not professional.'*

Mark explained that it was difficult to work from home, because if he did, his partner had to stay in the bedroom while the treatment was taking place. He had found a clinic space locally, near the station, and spent some time redecorating it to suit his needs and got a friend who he had met at a reflexology course to help:

*'I have a friend who's just very good at setting up things... when we were doing the course together ... she'd lay out her table and I thought yeah I really like the way that looks. I couldn't have come up with that but immediately I thought, yeah I want to emulate something like that, I like the feeling that gives.'*

The key difference between those who had disengaged and those that had made a partial transition was that they were still committed to their identity as a practitioner and were continuing to develop their professional knowledge. This included both *consolidating* their skills and *building confidence and new skills* in specific areas that they felt needed work within their practice. They all saw themselves as being on a learning and development trajectory, and saw the transition to practise as a new phase of their

education, i.e. learning what it was to *be* an osteopath or homeopath. For instance, Ricky explained that he was working to consolidate his clinical osteopathic skills and to build his confidence in communicating with patients, which he had identified as the weakest part of his practice. He explained that his previous career as a musician had not allowed him to nurture skills in '*normal human interaction*' and that his training did not support him to develop these skills. His current principal and mentor observed him working and suggested changes. He realised that:

*It was my lack of confidence, in the way that I speak ... was infecting them with a lack of confidence in me ... [my principal] said 'You don't need that... instead of saying 'Hopefully, you'll feel a lot better this week, but I'd like to see you next week' if you say to them, 'This will calm down this week. You'll feel much better, but I need to see you again in a week', they're hearing basically the same thing but they're hearing it in a much more, something that gives them a bit more confidence'. He said 'You need to – it's not so much harnessing the placebo effect, but it's making sure that you absolutely negate the nocebo effect'.*

Susanna was keen to develop a specialism around children and maternity care. Mark and Erika had taken additional training in reflexology and emotional freedom technique respectively to complement their skills in homeopathy.

One distinctive thing about the homeopaths, Erika, Mark and Lesley (and Joshua), was that they described the transformations they had made during training as so profound that they could not go back to their old lives (even if they were not practising full time).

For instance, Erika explained:

*'My holistic life that I've created for myself... it's my work but it's also my life you know and that consciousness around setting intentions and the importance of setting intentions and creating closure... it's just how I live my life now, all the time, it's just a way of being... I do very feel very established on a personal level but if you were to look at my bank account, I certainly wouldn't look it. And I think there's a certain level at which you have to measure your establishment and success in cold hard cash and [yeah] being able to make a living.'*

She noted that:

*'I need to find my inner business woman!'*

### Established practitioners

Three osteopaths, **Lois** (running an osteopathy and yoga clinic from her home in Hampshire), **Joanna** (working in a number of clinics in London) and **Kathryn** (about to be promoted to a partner in the osteopathy clinic that she works at in the East Midlands), and one homeopath, **Iona** (running a practice from two clinics and her home in Scotland) had become established practitioners in the years since they had graduated. They were

working full time and were earning enough to support themselves and their families. As well as knowledge and passion, these practitioners had developed entrepreneurial skills.

The conventional idea of an 'entrepreneur' is a person who works to identify gaps in the market and to fill them, which does not fit easily with the vocational nature of CAM practice. There is a tension between commitment to and passion for the therapy and being business-minded. This is a tension also seen in creative industries, such as music and art.

Nevertheless, discovering that setting up in practice is also about being in business is the core challenge in the transition. There may be similarities between these experiences and those of other healthcare professions operating in a private or semi-private environment such as psychotherapists, counsellors, private physiotherapists, dentists, optometrists, fertility consultants and GPs.

Some had what they later came to realise were unrealistic expectations of the ease with which they could become financially sustainable, for instance, Ricky explained:

*'In the first year [of my training], I expected to come out of college straight into seeing 10 patients a day, and earning £30,000 a year... I guess some time in my fourth year, once I started talking to the newly qualified osteopaths, hearing their stories about how difficult it is to get started.'*

With hindsight, most respondents felt that there was insufficient preparation for business in their basic training courses.

*'I wish they'd done a little bit more of the nuts and bolts, the mechanics of the job, and how to deal with patients, and the fact that it's a service industry. This idea that we were learning a business was just completely overlooked.'* (Ricky)

Without the guarantee of mentorship and support, new graduates could be at sea. The focus of the training courses seemed to be on the development of new knowledge and skills, and (more so in the homeopathy course) on communicative, self-development and reflective skills, i.e. what happens *in* the consultation. Much less attention was given to getting patients coming for treatment in the first place, of creating a bridge to potential patients by creating and marketing a service that is needed or wanted, i.e. what happens *outside* the consultation room.

A number of the participants noted that it was a challenge to start a business during a recession as people often cut back spending in austere times and were less inclined to try new things. It was also very hard for osteopaths or homeopaths to work within the NHS, even though osteopaths are statutorily regulated. Of the participants, only Aidan (osteopath) was working on an NHS contract (via a private physiotherapy company) but was still quite a vulnerable position and relied on private clients as well. Cara felt that the osteopathic profession needed to do more to be recognised by the NHS to provide clear job opportunities.

As Shane & Venkataraman (2000) have argued 'entrepreneurship is the process by which technical information is converted into services/products'. However, they also point out that 'entrepreneurially-driven innovation is the driving force in the changes in a capitalist economy.'

This latter point is perhaps the root of the ambivalence that many practitioners (and colleges) feel about the business side of practice, given that many have chosen to 'opt out' of conventional employment arrangements. These issues of identity can be summarised as whether the practitioner's primary identity<sup>5</sup> is:

- being a health practitioner, or
- being a person who makes a living out of being a health practitioner, or
- being a person who influences the wider health field

Practitioners used four different strategies to build up their practice and to create a sustainable business.

**Strategy One:** *Putting in the hours and hard work needed to start any business*

Iona explained that for the first few years, she had to work flexibly and be available for patients whenever they wanted appointments:

*'I love it, it's brilliant, it's a bit, lots of juggling but I'm quite good at juggling, I think when you're a single mum you have to anyway... but I do need to take more time out for me really... when you're self employed, up until two years ago... I would have like maybe a really, really busy month and then maybe one or two not so busy months and then a really busy month. It was a bit sort of like that up and down so when you had clients you just had to sort of go with it.'*

More recently, her list is sufficiently stable that she has started putting more boundaries in place around her time and rediscovering her work-life balance.

Lois described 'building slowly'. Initially, she worked from home and as an associate locally with an established osteopath and paying 50% of the patient fee. She explained that the other osteopath was 'renting the room, so when she's not there, having a break or doing something else, the room is generating money for her'. This gave her some experience, but then she moved to another clinic because the set-up was better:

*'I went there, partly a bit more income, busier clinic, see what other people are doing, and that was 48% of their take. But they've got admin support, there's many rooms there and its multidisciplinary, so osteopaths, acupuncturists, homeopaths, pilates teachers, all sorts, which is nice and easy because they take the bookings, and then I just invoice them on a monthly basis.'*

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<sup>5</sup> These descriptions of identity are adapted from David Rae's work on musicians and artists. See Rae D (2004) '[Entrepreneurial learning: a practical model from the creative industries](#)', *Education + Training*, 46(8): 492–500. See Appendix 1 for more detail and some practical tips on developing professional identity.

She came to realise that she preferred working at home because it allowed her flexibility with appointment length and to incorporate yoga into the treatment if patients wanted it:

*'I didn't feel I could work the way I work [at home]... and that's one of the reasons I left. I feel that my energy was more directed here and how I want to work, So that's all fine, we've been on good terms and again it's a great opportunity. You've got to do these things to find out.'*

It was also the most efficient way of earning income because she did not have to pay rent or associate fees: *'I'm in a low cost, low overheads position'*.

### **Strategy Two: Finding a marketing strategy that works for me**

Participants described many approaches that they had tried to advertise their services, such as distributing leaflets locally, yellow pages, advertising in local newspapers, posters in GP surgeries, going to fairs, doing talks and locating their clinic on the high street to pick up passing trade. Most were equivocal about the effectiveness of these methods in generating clients. In general, it was about raising profile locally and practitioners aimed to discover something that worked for them:

*'It's not individual advertising that works. I think it's just generally making yourself, making your name known around the area, and if people come across your name in several places, then when they need a homeopath, then they, you know, its familiar enough for them to go for, hopefully, you.'* (Lesley)

Iona linked this work to her wider personal and professional development.

*'I think part of [my success] is because I'm still doing personal development stuff... I think some people when you've studied and then you've gone into practice they don't necessarily... continue with that because they feel like they've qualified now, don't need to do that. That's not where I'm at. So I do shamanic work every fortnight and also the marketing stuff. I'm not really very good at marketing but I've found a style that works for me and so I do these talks [at a local health spa]... it's me telling people about homeopathy, it's just sort of sowing seeds.'*

Ultimately referrals from other practitioners, recommendations from other patients and returning patients were the most consistent ways to maintain a sustainable patient list. Lois explained, *'My proportion of my list that keep coming back is high ... it's got to be over 80%. And I tried advertising in a little local publication a couple of times, and it wasn't particularly fruitful and I don't bother [now]. It's all word of mouth'*. She explained that you had to understand your market:

*'I think there's a certain type of person that would come to a home practice than a shop fronted clinic, the type of person that comes to me, one's got chickens, she brings me half a dozen eggs from her chickens, somebody else brought me flowers*

*off her allotment... they want a relationship... it's not a commodity what I do. I think they want to be treated as a person.'*

Lois' comments illustrate a key part of being entrepreneurial, which is to be able to create a match between what you offer and what people want.

### **Strategy Three: Building a unique portfolio of skills**

Established practitioners had characteristics that made them different. These included both having other therapeutic skills in their repertoire, such as yoga or counselling, and specialist knowledge, such as around maternity or paediatrics. They also brought skills from their previous careers that were part of who they were and the 'package' that they could offer their clients:

*'I think it's probably something that's come from my acting actually and that I probably, and the fact that I'd been a masseur for probably about 15 years before I went into osteopathy so I'd had that skill. I also think – it's probably something that seems a bit natural I don't think it's something I've learnt because I've always been around because I – used to do loads of cycling, I've always been around older people, an age range of people and comfortable with that so I think it's, I'm not sure it's learnt I think it's just a bit natural.'* (Joanna)

This relates to the issue highlighted above of the importance of continued passion for the practitioner role and commitment to continual learning and development. Part of becoming an established practitioner was developing a unique skill set and identity that appeals to potential patients, such as developing advanced skills in a particular area of interest or bringing together different skills.

### **Strategy Four: Undertaking postgraduate training or associateships/apprenticeships**

All four practitioners who had become established in the 5–7 years since they had graduated had undertaken some form of structured continuing professional development, in the form of postgraduate training, additional qualifications or participating in a close apprenticeship/associate relationship with a mentor.

Postgraduate training (with a focus on practice-based learning) provided a structured format for reflecting on learning and a source of helpful support and discussion. Joanna described her masters in paediatric osteopathy as being a source of great inspiration and learning:

*'I volunteer at the osteopathic children's clinic once a week and I love that because the tutors there are just so much more knowledgeable than I am, all of them, so I'm just learning so much, and I do a bit of helping there with tutoring when they need to and you learn from that, so that's where I get my learning.'*

Nurturing and supportive associate positions or apprenticeships enabled development of clinical skills and business sense. Kathryn describes the director of her clinic (that she

is soon going to buy into as a partner) as her key source of osteopathic support in the early years of her career.

### **What does career progression look like?**

There is a flat professional structure in osteopathy and homeopathy from a regulatory perspective. Osteopaths are statutorily regulated and appropriate qualified practitioners are eligible to join the register. There is no additional legal recognition for advanced practice<sup>6</sup>. Homeopaths have a system of voluntary registration<sup>7</sup>, run by a four professional bodies<sup>8</sup>.

Returning to the kaleidoscope model of careers (authenticity, balance, challenge), what we can see is that practitioners start to refocus their efforts depending on their own personal circumstances and values. For instance, Lois is keen to work at home and to reduce her hours because she feels that she is a more authentic practitioner at home and because balance in her life is important:

*'I've reduced my working life to just working at home. Not because I didn't enjoy it, or it wasn't beneficial, but financially, you know, I can either work half as much or earn twice as much by not paying associate fees. And I have a lot of freedom within my practice to work how I wish to work.'* (Lois)

Iona, similarly, has started to place more boundaries on her work hours to regain some balance, ensuring that her practice is personally sustainable. However, she is also seeking new challenges and has set up a small training college of her own. Kathryn has cut down her patient-facing days to 4 days a week so she can have more leisure time and still spend half a day a week focusing on the challenge of the business aspects of her new role as a partner in the practice. She is also keen to become more involved at a regional level with the osteopathic community. Joanna is keen to develop a specialism around paediatrics and special needs osteopathy and is focusing more of her time on gaining experience of that area. She explained:

*'for me my career's not about structure as in I'm going to be tutor and then I'm going to be this and then I'm going to be a professor, it's about what area, what sector of the community I'm serving, that for me is what I'll expand into.'* (Joanna)

For Oliver, his ambitions were to undertake research in homeopathy rather than setting up a large practice. He wanted to bring his industry and project management skills from his previous career and his homeopathic knowledge together in a different way.

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<sup>6</sup> At the time of writing, the Osteopathic Development Group (<http://www.osteopathy.org.uk/about/our-work/Developing-the-profession/>) are conducting research on the viability on introducing an infrastructure for advanced clinical practice. I am consulting on this project that is being run by a social enterprise, Health Academix.

<sup>7</sup> The register can be found online at: <http://www.findahomeopath.org.uk/>.

<sup>8</sup> The Society of Homeopaths, the Alliance of Registered Homeopaths and the Homeopathic Medical Association represent professional homeopaths (non-medically trained), and the Faculty of Homeopathy represents medically-trained homeopaths. No medically-trained homeopaths were included in this study.

Another approach to career progression was building up a business model that is sustainable beyond the direct client-facing work. In most cases, providing osteopathy or homeopathy requires being in the physical presence of the patient for a fixed period of time, limiting the extent to which you can increase the efficiency of the service or increase income. Methods of doing this could include taking on staff or running a multi-practitioner clinic, developing passive forms of income, such as writing books, or teaching or running a college to train other practitioners.

In summary, in the absence of established career paths, CAM practitioners are carving their own paths and creating a sense of progression through enhancing the challenges, balance or authenticity in their lives.

## **[2] Creating professional networks and building a community of practice**

Independent healthcare practice can be a lonely business. Aidan noted that there were few opportunities in daily practice to interact with others: *'basically you're just stuck in a little room so you know what have you got to compare it with... I'm a one-man support network'* and Lois pointed out that there was little sense of a professional community: *'As a profession we don't have any of that. I feel you've paid your money, you're on your own. That is what it feels like'*. However, many of the participants in the study were able to show ways in which they tried to cultivate their own networks of support.

To start the conversation about social networks with participants, I got a blank sheet of A3 paper and a pen and asked them to put their names in the middle of the paper and then add friends, family and colleagues and any other things they considered support in a 'map'. Mostly, they drew lines to each person with arrows of different sizes to indicate the direction and importance of the support.

### **Who (and what) was part of the participants' support networks?**

There was a large range of responses to this which included:

- Family/partner
- Friends
- Other practitioners (same therapy), including other graduates from their college
- Other healthcare practitioners (different CAM therapies)
- GPs and other conventional healthcare practitioners
- Supervisors/mentors/tutors
- Boss/ Practice partners/ Clinical principal
- Spiritual practices
- Online social networking



- Institutions (colleges, professional organisations, regulatory organisations, campaigning organisations)
- CPD courses
- Books
- Magazines/ written materials/ online materials

Discussing these different sources in more detail, it was possible to group the types of support into five areas<sup>9</sup>:

- *Instrumental support* – this is the provision of tangible assistance in the form of money, goods or services, that you would not be able to do yourself for any reason such as time or skills. For instance, Iona's partner designed all her marketing materials.

- *Emotional support* – this is when another person is caring and empathetic and is based on love and/or trust. For instance, Mark described discussing with his partner his decision to leave his previous career and think through future career options.

- *Informational support* – this is when at a time of need or stress, useful information is provided that you would not otherwise have access to. For instance, Lois described how she has used online social networking to access information and discussions about aspects of her practice that she wants to develop further.

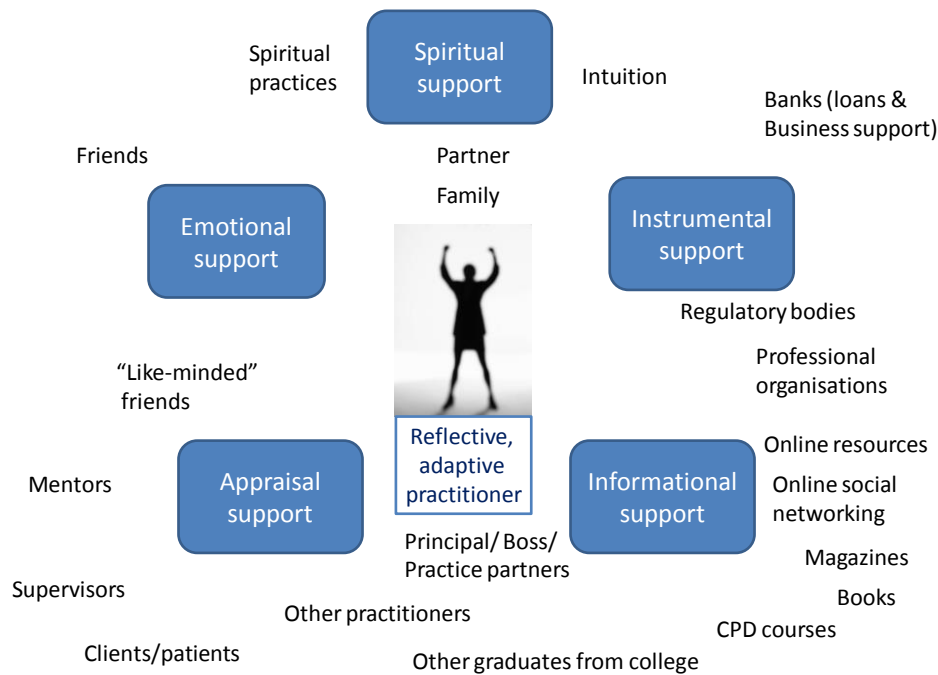
- *Appraisal support* – this is when support is providing input in some form that allows for self-evaluation and reflection. It could include critiques of the person's actions, or suggestions that they might have different options available to them. The key to appraisal support is to encourage the person to think through the issue and resolve it themselves rather than offering solutions. Erika described having a group of women, who were also health practitioners, who met on a regular basis to discuss their lives and work.

- *Spiritual support* – this is when practices or interactions give a sense of connection to spirit, nature or other people but are not 'tangible'. Joanna described her relationship to God as being a huge part of her support for her practice. Erika on the other hand described a more secular method of achieving this kind of support through singing and chanting.

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<sup>9</sup> The first four types of support – instrumental, emotional, informational and appraisal – are defined in articles by Langford et al. (1997) *Social support: a conceptual analysis*. Journal of advanced nursing 25(1):95–100 and Berkman et al. (2000) *From social integration to health: Durkheim in the new millenium*. Social Science & Medicine 51(6):843–857. The fifth, spiritual support, emerged as a new category of support from the data in this study.

Not all participants described all forms of support, but generally certain types of support clusters around certain sources of support as Figure 2 shows:



*Figure 2: types and sources of support for practitioners*

### **'Sustaining' links**

A key concept to emerge from the data in this study was the importance of 'sustaining' links in the network. This contributed to the adaptive resilience of the practitioner, which is particularly important in a marginalised profession where support and encouragement for your choice of career are not by any means universally present. Participants described that even within their own families and close friends, they encountered sceptics. Unlike in college where they were surrounded by others learning the same skills and knowledge, as a graduate they were re-embedded in their local communities. They had to actively search for people with whom they could have open discussions and critically appraise and reflect on their own identity and practice. An important characteristic of this situation was that in discussions there was a blurring of the designation of 'friends' across a range of different identities. Friends could be other practitioners who were clients or mentors as well. Participants described undertaking 'swaps' with other practitioners as well as meeting for coffee to discuss work and life.

Participants tended to only describe a few close, sustaining relationships because although they were very rewarding and essential for their well-being, they required a lot of emotional energy. These were the only relationships where appraisal support was involved, because they required trust and respect for their person's knowledge and experience in the field. Lois explained that she always made the effort to meet a colleague every couple of months:

*'We get together as friends, but have wide-thinking conversations'.* Erika describes finding a particular strength of support from *'other people who are on a spiritual journal like you and who are wanting to be their mission'.* She likened it to the phrase in the famous children's book, *Winnie the Pooh*, *'Then would you read a Sustaining Book, such as would help and comfort a Wedged Bear in Great Tightness?'* (see Figure 3).



*Figure 3: 'Then would you read a Sustaining Book, such as would help and comfort a Wedged Bear in Great Tightness?' — Winnie the Pooh*

There was a clear sense that they were part of a loose, 'alternative' community for CAM practitioners, *'That's all part of this sea of complementary medicine, and it brings me into contact with people where there are opportunities for practice'* (Oliver). The creation of your own close 'sustaining' network was the work of each individual practitioner and none looked the same. Susanna explained that the choice of who to spend time with depended on how you want to be as a practitioner: *'depending on what you follow, you'll find your support groups maybe in a different direction'.*

Sociologists have studied the characteristics of networks and two important aspects are the 'density' of the network and the strength of the ties or connections within them. Dense networks with strong ties are more useful for accomplishing operational goals because you understand deeply how others work and can make things happen, whereas sparse networks with, so-called, 'weak' ties are better for learning new things and for change because they expose you to new ideas. Iona, while describing herself generally as a 'self-sufficient' person, had a rich tapestry of networks locally and nationally that she called on. This involved both extremes – her closest colleagues and friends, such as those who were teaching at her college, as well as those who she spoke to much less frequently but with whom she was able to discuss wider developments in the profession.

## Communities of practice

Communities of practice are where a group of practitioners (of any kind) undertake collective forms of learning over an extended period of time. This allows them to develop as a group that which is greater than the sum of its parts and can contribute to the extension of knowledge, methods for problem solving, or improvements in support or coordination of activities. Nurturing communities of practice has been seen as a 'good thing' for quality and safety of healthcare<sup>10</sup>.

In the profession, some comments suggested that it might be difficult to develop a good community of practice. Aidan said, 'You know that old joke, the plural of osteopath is argument' and Erika said, 'We can't even agree how to spell homeopathy/homoeopathy!' However, there were plenty of examples of ways in which people were coming together to develop an open, questioning but supportive environment to develop knowledge and practice. At an individual level, this manifested in the form of good associateships or peer mentoring. Ricky described how students from his own college come to his clinic to shadow the osteopaths there, and how his principal sits in and shadows him sometimes to help develop his practice. At the profession-wide level, cultivating communities of practice happened through the involvement of professional organisations or the development of journals for sharing and debating ideas. Susanna described finding the British Osteopathic Association really helpful in terms of jobs listing, updates on standards of practice and on new research happening in the field. However, there is certainly more that could be done<sup>11</sup> by colleges to prepare students, by professional bodies to support their community of practitioners and by individuals to contribute to their own communities.

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<sup>10</sup> Ranmuthugala et al. (2011) '[How and why are communities of practice established in the healthcare sector? A systematic review of the literature](#)', *BMC Health Services Research*, 11:273

<sup>11</sup> For more information on ways in which professions can support clinical quality and safety, see Wilkinson & Gale (forthcoming, 2015) 'Towards a learning profession? Adapting clinical governance for complementary and alternative medicine', chapter in Gale & McHale (eds) [Routledge Handbook of Complementary and Alternative Medicine: Perspectives from Social Science and Law](#). London: Routledge.

## What are the implications of this study for the sector?

The study has implications for individual students and practitioners, but also for educational institutions, professional organisations and regulators.

Central to the findings was the importance of cultivating entrepreneurial learning within the CAM professions. Being part of a community of practice is one place in which practitioners can develop entrepreneurial skills by learning through practice. David Rae wrote an article in 2004, called ‘Entrepreneurial learning: a practical model from the creative industries’<sup>12</sup>, which I have adapted for CAM practitioners based on the data collected in this study (see Appendix 1). It involves reflecting on three interconnected parts of setting up a practice – the practitioner’s own emerging identity, learning about the context and environment in which their practice is located, and being aware of the need to adapt and negotiate as new circumstance arise. The important message is that making a living from CAM practice is not just about getting your own self in order (your knowledge and skills), but also involves thinking about yourself in relation to the world around you in a critical and reflective way.

First, a practitioner needs to think about themselves, what they want to achieve and what pattern in the career kaleidoscope they are ideally looking for currently. Mark described in depth how during his training, he struggled to find his identity as a male homeopath (the profession is predominantly female) and explained that after he took a year out from the course, he returned and joined a class with other men who he found he could identify with. They embodied a very different sort of masculinity to the men he had worked with in his previous career, in terms of having emotional strength and adaptability, which he found empowering.

Second, a practitioner needs to look at the world around them and try to understand the structures they are working within (laws, regulations, financial systems, values and culture) to see how they fit in and where there is opportunity for them to make a contribution. Participants in the study described learning from their tutors at college and each other about the challenges of the real world of practice, but often quite late on in their training. Once they graduated, they started to develop and refine ‘practical theories’ about what works for them and in what circumstances, such as effective marketing strategies.

Third, they need to be ready to adapt when things change – either at a personal or structural level, which they inevitably will. When changes happen it is helpful to use support networks to think through strengths and gaps. The practitioners in this study found that as they grew their support and referral networks it improved the resilience of their practice. They also sometimes had to take risks to respond to changes in themselves or the environment. Lois described giving up her job at a clinic to focus on growing her home practice because it was more in line with her values and chosen lifestyle. Iona described having to reconfigure her practice profile when her contract at a community centre was suddenly terminated because of changes in policy at board level.

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<sup>12</sup> Rae D (2004) ‘[Entrepreneurial learning: a practical model from the creative industries](#)’, *Education + Training*, 46(8): 492–500

These kinds of skills can be practised and embedded during training, for instance by ensuring that clinical training mirrors real practice as much as possible, and by supporting students to think through how they will manage the transition to practice. Simply making the fact that there will be a transition understood could be potentially very empowering for new graduates. Post-graduation, providing support for the transition could have a significant impact on the number of graduates building successful practices. Techniques such as mentoring, postgraduate training or supervision are promising methods for doing this. Throughout a practitioner's career, professional organisations and clinical groups (for instance within multi-practitioner clinics, or in local/regional groupings) can do a lot to ensure that communities of practice thrive and support their members to become more resilient practitioners.

In conclusion, the study sought to make sense of the varied experiences that graduates from CAM courses have when trying to set up a practice post-graduation. Through in-depth interviews and clinical observations, four main messages emerged from the study for CAM practitioners and the organisations that represent them:

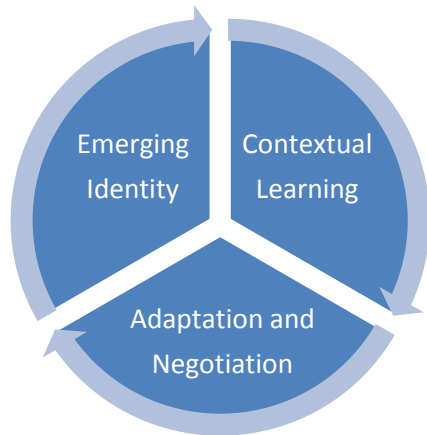


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**Social learning for independent practitioners/small businesses**

The themes are adapted from David Rae’s article ‘Entrepreneurial learning: a practical model from the creative industries’<sup>13</sup>. The questions have been adapted and added to, based on Nicola Gale’s research<sup>14</sup> with osteopaths and homeopaths making the transition from professional training to practice.



<p><b>Emerging Identity</b></p> <p>Creating an identity as a practitioner running a successful business is the result of both personal development and social learning.</p>	<ul style="list-style-type: none"> <li>- What are the five most important values to you?</li> <li>- How do you tell the story of your life? What role does work play in it? Does having an entrepreneurial spirit feature in it?</li> <li>- What parts of your practice do you feel excited or passionate about?</li> <li>- How do your aspirations for your practice fit with your role in your family or friendship group?</li> <li>- What are you good at doing? How can you use these talents for your business? Where do you need support?</li> <li>- What do you want to achieve? What would count as success?</li> </ul>
<p><b>Contextual learning</b></p> <p>Being able to recognise and act on opportunities requires you to learn about the context and environment that you are setting up your practice in.</p>	<ul style="list-style-type: none"> <li>- What are the most important things that you have learnt about running a practice since you started doing it?</li> <li>- What ‘works’ on a day-to-day level for you when running your practice? With whom? Are there any instances when these ‘practical theories’ have stopped working? Why?</li> <li>- What relationships and contacts have you formed within and outside of the practitioner community that help your practice?</li> <li>- What ideas have you had for potential new developments to your practice? How can your contacts help with this development?</li> <li>- Are there any things that you feel you cannot change (structures or attitudes) in your professional field? How can you negotiate these?</li> </ul>
<p><b>Adaptation and Negotiation</b></p> <p>Being able to grow or refocus your practice over time requires you to be able to adapt yourself and your practice, and to negotiate with others.</p>	<ul style="list-style-type: none"> <li>- Who can you talk to about your practice honestly? Do those conversations enable you to reflect and appraise where you are and where you are going?</li> <li>- How effectively do you work with others towards shared goals? Do you know what your preferred role is in a team?</li> <li>- What are the most important external relationships for your business?</li> <li>- How is the patient/client engaged in the way you develop your practice?</li> <li>- What sorts of feedback do you receive? Are you prepared to take feedback seriously?</li> </ul>

<sup>13</sup> Published in the peer-reviewed journal *Education + Training* (2004, Vol. 46, no.8/8, pp. 492–500).

<sup>14</sup> The research project was funded by the Economic and Social Research Council and based at the University of Birmingham (for further information, see <http://www.esrc.ac.uk/my-esrc/grants/ES.J002828.1/read>)



## Feedback

It would be really useful to hear your thoughts and feedback on the research and particularly whether it is likely to have any impact on your practice or the policies of your organisation (if applicable).

- 1. Please tell us about yourself, e.g. are you a practitioner? What type? Are you involved in activities in the profession more widely?**

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- 2. What are your top 3 'take home' messages from the report?**

(i).....

(ii).....

(iii).....

- 3. Will reading this report have any impact on your practice/ policies? If so, what?**

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- 4. Do you have any other comments or feedback?**

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Please email any comments to Nicola at [n.gale@bham.ac.uk](mailto:n.gale@bham.ac.uk) or [n.k.gale@gmail.com](mailto:n.k.gale@gmail.com)

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