3(Byong-Hee CHO) 2009.10.15 8:23 페이지44 N0.3 P2400_CMYK

Two Paths for Alternative Medicine:
Professionalization of Oriental Medicine and the Growth of Lay Acupuncturists in Korea

Byong-Hee CHO

Abstract

Alternative medicine is popular in Korea, as it is in Western societies. This paper aims to review the current state of alternative medicine, especially the growth and division of oriental medicine. In the modernization period, practitioners of oriental medicine were divided into a majority of regular oriental medical doctors (OMDs) and a minority group mainly composed of acupuncturists. OMDs have professionalized their work, while acupuncturists have seen their social status fall. OMDs promoted the professionalization of their medical practices and monopolization of knowledge. In contrast, acupuncturists have taken a more popularist approach, advocating low-tech therapy and sharing knowledge among people. Recently, they have advocated a popular health movement by training lay acupuncturists and providing free services. This paper discusses the factors that cause this two-tier approach and the limits of professionalization and the popular health movements.

Keywords: alternative medicine, CAM, medical doctors, oriental medical doctors, acupuncturists

* This work was supported by a Korea Research Foundation Grant (KRF-2007-411-J01601, 602).

Byong-Hee CHO is Professor of the Graduate School of Public Health at Seoul National University. He obtained his Ph.D. in Sociology from the University of Wisconsin-Madison in 1988. His publications include *Seksyueolliti-wa wiheom yeongu* (Sexuality, Risk, and HIV/AIDS) (2008) and *Jilbyeong-gwa uiryo-ui sahoehak* (Sociology of Diseases and Health Care) (2006). E-mail: chob@snu.ac.kr.

www.kci.go.kr

3(Byong-Hee CHO) 2009.10.15 8:23 페이지45 NO.3 P2400_CMYK

The Discourse and Politics of Alternative Medicine

Alternative medicine has grown rapidly in popularity over the last 30 years. In the early 1970s, people involved in the practices were regarded as "limited, marginal, and quasi practitioners" by sociologists (Goldstein 2000, 284). Medical doctors usually called it "quackery," "unorthodox," and "unscientific." Now, it is called "alternative medicine" or "complementary alternative medicine" (CAM). People in advanced societies have become more interested in alternative medicine and utilized it frequently. Eisenberg's study in the United States indicated that 42 percent of Americans had tried at least one alternative therapy in 1997 (Eisenberg 1998). CAM also became a valuable commodity; the Eisenberg study estimated health care expenditure for alternative medicine at US$27 billion in 1997.

Alternative medicine has also become popular in South Korea. One survey in 1999 showed that 29 percent of respondents had used complementary therapies, spending an estimated US$4.6 billion, or 40.8 percent of health care expenditures for biomedicine (Lee 1999). Places for alternative medicine such as yoga studios, massage parlors, aroma therapy shops, medicinal herb shops, acupuncturists, meditation studios, and *gi* (*qi* in Chinese) training are readily accessible and found on most streets. Some local governments even offer CAM courses to residents.

In Western societies, the New Age and the spiritual health movements influenced the rise of alternative medicine (Baer 2004). Skeptical of Western science and technology, the New Agers sought alternative ways of life emphasizing a holistic approach to spiritual and physical well-being. Dissatisfaction with biomedicine and the desire for a more pluralistic and holistic approach to health in postmodern society were factors motivating the use of alternative medicine (Bakx 1991). However, CAM users are not always or completely critical of biomedicine (Thomas 1991; Astin 1998). They usually use both conventional and CAM methods of treatment.

The situation in Korea is somewhat different. There have been no New Agers and little cultural critique of science and technology.

www.kci.go.kr

3(Byong-Hee CHO) 2009.10.15 8:23 페이지46 N0.3 P2400_CMYK

High-tech medicine is associated with high quality of care, and the practice of CAM by unlicensed laypersons is legally prohibited. Despite these unfavorable conditions, a diverse range of CAMs have been introduced, utilized, and practiced by laypersons.

This paper will focus on the sociological characteristics of CAM, rather than its philosophical properties, such as spirituality. The most distinguishing sociological feature of CAM is the less differentiative relationship between providers and consumers, a common characteristic of premodern medicine (Coe 1970, 125). Once professionalized, practitioners differentiate themselves from consumers by monopolizing medical knowledge. Since Parsons (1951) and Freidson (1970), sociologists have agreed that biomedical power has been formulated through the monopoly of medical knowledge and through the construction of hierarchical health care division of labor. Unlike biomedicine, CAM is marked by unmonopolized and undifferentiated health care. Goldner (2004) found that CAM users shared knowledge and techniques. The CAM users' active participation in the treatment process can also be contrasted with non-CAM patients' dependence on and obedience to medical doctors (Hughes 2004).

Another issue is to clarify the politics of alternative medicine. There are several dilemmas facing the development of CAM. The one strategy is to preserve the alternative nature of CAM and the undifferentiated relationship among users and providers. However, CAM leaders attempt to upgrade their social status and legitimize their work through professionalization. Once professionalized, the CAM might obtain the political supports for scientific research and the recognition of Western medical doctors (Goldstein 2000; Saks 2001). However, professionalization means the transformation of alternative medicine into a complementary medicine (Cant and Sharma 1996, 1999). Some CAM groups have tried to institutionalize by conforming to the standards of modern health care, losing their alternative nature and becoming a part of mainstream medicine. Professionalized CAM has the potential for recognition in the formal health care system. However, their relatively marginal status within the health care division of labor continues (Saks 2001).

www.kci.go.kr

3(Byong-Hee CHO) 2009.10.15 8:23 페이지47 N0.3 P2400_CMYK

Korean oriental medicine is a very interesting case. In the modernization period, practitioners of oriental medicine were not fully integrated as one occupational group. The majority of the practitioners became regular oriental medical doctors (OMDs), but a minority remained specialized as acupuncturists.[1] Since then, OMDs have professionalized, and their social status in Korea is now similar to that of Western medical doctors (MDs). Acupuncturists, conversely, have seen their social status fall and very few remain in active practice after the abolition of the acupuncturist system. One leading acupuncturist Kim Nam-su trained thousands of lay acupuncturists to practice informally. He recently advocated for a popular health movement promoting moxibustion, saying, "Learn it and give its benefits to other people." While having the same theoretical background as oriental medicine, the two groups have taken different approaches. OMDs promoted the professionalization of their medical practices and monopolization of knowledge, while the acupuncturists preferred low-tech therapy and sharing knowledge among people.

There are two conflicts within the health care division of labor. First is the relationship between MDs and OMDs. MDs try to protect their job boundaries from the encroachments of OMDs. Second is the relationship between OMDs and acupuncturists. OMDs suppress acupuncturists and popular health movements. I will discuss the complicated politics of health care and their impact on the health care division of labor.

Spiritual Well-being, Shared Knowledge, and Self Care

The New Age movement is usually cited as the origin of the CAM movement in the West. New Agers are skeptical of science and technology, and desire a religious-spiritual reorientation towards natural

1. Acupuncturists are currently composed of two groups: a small number of licensed acupuncturists and unlicensed practitioners. In this paper, I will use the term "acupuncturists" for both.

www.kci.go.kr

3(Byong-Hee CHO) 2009.10.15 8:23 페이지48 NO.3 P2400_CMYK

healing. For them, the individual is responsible for one's own life and seeking means of transformation to achieve a better quality of care. They seek inner peace, wellness, unity, self-actualization, and attainment of higher consciousness. Healing represents a homeostasis or balance between physiological, emotional, and spiritual powers (Baer 2004, 9-12). Healing and attaining health is a core strategy of realizing their ideal world.

In Korea, the situation is quite different. There has been no such spiritual health movement. Science and technology have been respected as the impetus for economic growth and prosperity. Biomedicine itself is usually not criticized, and when it is, it is usually for MD's authoritarian attitudes and high expense. By criticizing science and technology, new age spiritualists try to obtain control of their own body beyond the conventional medicine's technological and biomedical control over the body. In Korea, the concept of subjective control of the body has not yet grown up under the dominance of biomedicine. Oriental medicine also does not provide an alternative approach to health. Usually, people argue that oriental medicine addresses different properties from biomedicine; oriental medicine is philosophical, subjective, holistic, defensive, empirical, moderate, and health-oriented with an emphasis on the role of organs, while biomedicine is scientific, objective, analytical, aggressive, experimental, and accurate, with an emphasis on the function of organs and disease (Jeon S. 2000). While both have different etiology and therapeutics, they also have common properties such as a lack of concern for clients' roles, overemphasis on treating symptoms, and an individualistic approach. They also lack a concept of social influence on health. Holism in this context has very limited implications. In oriental medicine it means the interconnection between individual bodies and the natural environment where *gi* circulates. Without spirituality or an association with a counterculture, professionalized oriental medicine tends to emphasize the role of OMDs over empowering ordinary people in the process of reactivating blocked *gi* circulation. The presumed health orientation of oriental medicine also does not mean the self-actualization of one's own inherent capacity for health, but the revitalization

www.kci.go.kr

3(Byong-Hee CHO) 2009.10.15 8:23 페이지49 NO.3 P2400 CMYK

of physical health through the intervention of professionalized OMDs with prescribed herbs and acupuncture treatment.

The power of biomedicine is closely related with the concept of health. Health was considered the shadow of disease until the 1960s because it did not have its own properties (Radley 1994). Health meant simply the absence of disease. The healthy were those who were not ill or not biologically disadvantaged (Blaxter 2004, 5). Since treating disease was the sole domain of doctors, people had to seek professional medical care and comply with doctor's orders in order to be healthy. Parsons theorized patient behavior in 1951 as power relationship between dominant doctors and obedient patients was formally recognized with patients playing the "sick role" (Parsons 1951).

The situation has changed since the 1970s. Health now means balance, homeostasis, and fitness (Blaxter 2004, 7-9), which cannot be provided by ordinary medical treatments of disease. In order to obtain health, people have to make individual efforts. Instead of disease and dependence on professional care, health and self care have become a trend in postmodern society. In the 1950s, the body was considered as castle or machine, and health risks resided in the environment, not in the body. Sanitation meant the cleaning of our bodies where they contacted the environment. In contrast, now the body is regarded as a flexible immune system. The focus has moved from outside viruses to interior immune capacity, creating the need to immunize, cultivate, and train our bodies to maintain health (Martin 2000). The flexible body is susceptible to health risks such as hypertension and diabetes mellitus. We are required to be alert for risks, quit smoking, and start exercising. A healthy body becomes an identity, and self care becomes an individual responsibility.

Self care has diverse origins. Since the 1980s, health promotion has been a strategic goal of most advanced countries. Even public health and biomedicine emphasize self care. World Health Organizations carried out a worldwide campaign called Health-for-All (WHO 1978). Governments, academics, and commercial and popular sources paid more attention to health and health promotion (Burrows 1995).

www.kci.go.kr

3(Byong-Hee CHO) 2009.10.15 8:23 페이지50 N0.3 P2400_CMYK

Health conditions changed and health care expenditures increased. Most important health problems in advanced societies are now chronic, noncommunicable diseases such as cancer and hypertension. People now have to monitor their own health conditions and regulate their own bodies for primary prevention. Unlike the communicable diseases of the past, doctors could not promise restoration of perfect health, but instead try to prevent problems from worsening and maintain the current state. In addition, the patients or individuals are expected to improve their behavior to comply with standards of health. Due to soaring expenditures for treating diseases, the government organized a campaign for health promotion, and phrases like "Don't smoke. Don't eat or drink too much. Exercise for your health" are everywhere.

The governmental view of health promotion is based on the concept of the "medicalized body" (Turner 1996), which is regulated physically and socially by medicine, replacing the role of religion in maintaining moral standards in society. Smoking, drinking, and eating become new risks for health. Our body is to be taught, improved, and under surveillance in order to prevent new risks and maintain the medicalized body. This concept of health promotion has been criticized for its implication of victim-blaming (Nettleton and Bunton 1995; Lupton 1995). At the structural level, health promotion neglects material disadvantages in people's lives. Changing habits may have only marginal health effects on poor people. Health promotion usually requires patients to keep a health diary and take part in the routine physical check-up system. Sociologists criticize it as Foucaudian panopticism, creating the "health promoting self." Health promotion also pushes a cultural consumption of health. Since health becomes a new lifestyle, healthy foods products and even healthy housing need to be purchased. It becomes a new way of dividing individuals and achieving new social status.

Recently, some sociologists have tried to explain health care utilization as a consumer behavior. Consumption is a subjective action to obtain collective identity. Consumers of alternative medicine engage in the action because of their belief in holistic health and a

www.kci.go.kr

3(Byong-Hee CHO) 2009.10.15 8:23 페이지51 NO.3 P2400_CMYK

common sense of identity with other consumers of alternative medicine (Goldstein 1999). In the Bay Area of California, Goldner (2004) found that most respondents believed that using CAM and improving their own health are forms of activism. It was different from conventional social movements in which leaders set up goals and organize participants. Individuals using CAM techniques also educated others about the techniques and uses. Unlike conventional social movements, they may not agree on a formal goal, but they hold a common sense of identity through consuming alternative medicine. They share health knowledge and techniques on the basis of mutual trust and respect within personal relationships. They adhere to CAM not just because of the results, but because of the beliefs behind these techniques. In this type of consumption and knowledge sharing, the relationship between practitioner and consumer tends to be equal.

Self care is a very complicated concept. It is a process of self-actualization and self-empowerment, but it is also a process of becoming a disciplined body. Theoretical discussions of such differences are not the aim of this paper. Rather, I will focus on two different processes of approaching health knowledge: The sharing of and monopolizing of knowledge. these two processes divide conventional medicine, emphasizing monopoly of knowledge and discipline, and alternative medicine, emphasizing the sharing of the knowledge and self care in the Korean context.

Same Origin, Different Goals[2]

Acupuncture has been one of the major therapeutics of traditional oriental medicine in Korea. During the Japanese colonial period, acupuncture was practiced both by OMDs and acupuncturists. In Japan, oriental medicine was abolished except for acupuncture, which was a primary source of employment for the blind (Lock

2. This part of the rise and fall of the acupuncture system has been rewritten on the basis of my previous paper (Cho 2003).

www.kci.go.kr

3(Byong-Hee CHO) 2009.10.15 8:23 페이지52 N0.3 P2400_CMYK

1980). In Korea, oriental medicine had been maintained temporarily due to the shortage of medical doctors. But the acupuncturist system was newly introduced as like as in Japan. This two-tier system of oriental medicine doctors and acupuncturists was maintained until 1962, when the Park Chung-hee government abolished the acupuncture system and forbade its practices.

With the Park government's economic development and modernization policies, the Medical Act was amended to enhance the qualifications of medical workers. For instance, nursing education was needed to take place at the college level rather than at the high-school level. The government tried to abolish the oriental medical system, accusing it of being unscientific and premodern, but organized opposition from OMDs frustrated the government's attempts. The Park administration decided to maintain the OMD system, but upgrade their credentials by extending the education period for certification from four to six years, the same as for biomedical doctors. In contrast, the acupuncturist and bonesetter systems were abolished in 1962. Acupuncturists were not as strong or organized as OMDs and were unable to successfully defend their interests.

The Japanese colonial government established the modern health care system based on Western biomedicine, but also allowed the unorthodox practitioners, such as acupuncturists and bonesetters, to survive outside the formal health care system because of a shortage of medical doctors. The Park Chung-hee administration divided alternative medicine into authorized oriental medicine and unauthorized alternative medicine. Oriental medicine survived, but other alternative medicines were expelled from the health care market. Unauthorized practice was punishable with up to two years' imprisonment, with exceptions for licensed acupuncturists.

Thereafter, OMDs were able to develop their field into a professionalized medical practice. As the economy grew, popular need for oriental medicine expanded, along with institutional infrastructure. In the 1960s, there was only one college for the study of oriental medicine. Numbers have increased dramatically in the last three decades, and now there are 11 schools of oriental medicine attached to regular

www.kci.go.kr

3(Byong-Hee CHO) 2009.10.15 8:23 페이지53 N0.3 P2400_CMYK

universities, and 137 general hospitals with 8,245 beds that specialize in oriental medicine as of 2007.

However, the growth of oriental medicine has provoked conflicts among MDs, pharmacists, and OMDs. MDs demanded the integration of biomedicine and oriental medicine, a measure rejected by OMDs, who thought that the integration implied an extinction of oriental medicine. The offending MDs' proposal for integration seems to have been an attempt to reconfirm Western medicine's dominant position within the health care system. However, a more important conflict took place between OMDs and pharmacists in 1993, when pharmacists tried to expand into the increasingly popular field of oriental medicine. OMDs were organized to defend their market. A series of street demonstrations and a general strike wherein pharmacies closed their doors took place over several months.[3] As a result, pharmacists obtained the right to deal in some herbal medicines. OMDs obtained more substantial privileges: governmental recognition and support for future development. At the time, the government had not considered OMDs when designing and implementing health polices, and there was no administrative or financial support for oriental medicine. However, OMDs also had to pay a price for the recognition of their profession. The challenges from MDs and pharmacists were elicited in part because of the perceived "unscientific" nature of oriental medicine. OMDs were supposed to prove its effectiveness through standard scientific methods. In the past, OMDs had defended their position by emphasizing the inheritance of their traditional work as a part of Korean heritage, calling it "national medicine" (*minjok uihak* 民族醫學) instead of ethno-medicine.

Following the struggle with pharmacists, OMDs were forced to reorganize themselves to follow standard medical and epidemiological practices. They began to conduct scientific research and experiments, and to report results through international science journals. One sociologist observed the process of scientific research in an ori-

3. Conflict between OMDs and pharmacists was discussed in detail in my previous paper (Cho 2000).

www.kci.go.kr

3(Byong-Hee CHO) 2009.10.15 8:23 페이지54 NO.3 P2400_CMYK

ental medical college, describing the emergence of a hybrid medicine (Kim 2005, 2007). Scientific and biomedical theories and methods were adopted to explain and prove the effectiveness of oriental medicine. Even modes of speech have changed to incorporate English terminology instead of old Chinese characters to explain patient's illness or the results of research. OMDs are on a path to successful professionalization and their knowledge is now too specialized for untrained people to easily understand.

Acupuncturists took a different approach to keeping their field vital. From the beginning, the number of licensed acupuncturists was small and their socioeconomic status was low. Initially, some acupuncturists petitioned the National Assembly for the restoration of the acupuncturist system (Lee 1973). There were eleven attempts over a period of 40 years, to no avail. While oriental medicine became more professionalized, the acupuncturists' petition failed to gain attention at the National Assembly. In the early 2000s, acupuncturists adopted a new strategy of educating and sharing knowledge of acupuncture among ordinary people, just as improvement in economic conditions made people more concerned with health promotion. OMDs were able to expand their market due to changing socioeconomic conditions, but acupuncturists also took the opportunity to attract new people. After the implementation of National Health Insurance in 1989, the utilization of health services increased rapidly. In-patient procedures increased from 1.3 million in 1985 to 3.8 million in 2000. Out-patient treatment also increased from 43 to 108 million visits.

However, increased use of health services also led to increased dissatisfaction among patients. Less than 30% of the respondents in the Social Statistics Survey in 1999 were satisfied with the care they received, with respondents citing expense (45%), unsatisfactory treatment (36.4%), long waits (39.9%), and insufficient time allotted to treatment (22%) as their principle complaints (KIHASA 2001). The situation could be summarized as "3 hour waiting, 3 minute treatment, and no communication between doctor and patient except a few questions." This general dissatisfaction with health services is

www.kci.go.kr

3(Byong-Hee CHO) 2009.10.15 8:23 페이지55 NO.3 P2400_CMYK

a potential cause for some to seek alternative therapies, avoiding dependence on authoritarian medical professionals. In the 1960s, people used alternative medicines because of economic difficulties. In the 2000s, they use CAM to supplement regular health services and out of dissatisfaction with conventional medical treatment.

In addition to older therapies like acupuncture, diverse alternative medicines, such as hand acupuncture and aroma therapy, became available in the 1990s. Others, like *gi*-training and yoga, were rediscovered in terms of health benefits. Alternative medicine practitioners often opened small educational facilities on the side to teach theory and techniques to student healers. They also formed an association for healers. The association conducts qualification tests and confers credentials. Korean hand acupuncture was the prototype for this approach. Yu Tae-woo developed the technique in 1975 and started the relevant association in 1977.[4] The association offered a two month course in hand acupuncture therapy, published books, and sold needles and other supplies. It rapidly became popular domestically and abroad in countries like Japan and the United States. Over the course of the 1980s and 1990s the association continued to expand, and consequently local centers can be found in most cities in Korea.

The acupuncturist Kim Nam-su was born in 1915 and obtained a license from the old colonial government, and has practiced acupuncture on a voluntary basis since the 1980s, in addition to their own job activity (Kim 2002). Responding to popular demand, he opened a private institute offering a one-year course of acupuncture education to ordinary people. This institute produced 3,674 graduates as of 2007 (KHIDI 2008). The majority of graduates obtained certification through the school, although the license is not recognized officially by the government. Kim argues that acupuncture and moxibustion are cost-effective and easy to learn and has lead a popular movement for teaching moxibustion therapy (Kim 2002). Students of his school are expected to provide therapy to others on a voluntary basis.

4. http://www.soojichim.com/

www.kci.go.kr

3(Byong-Hee CHO) 2009.10.15 8:23 페이지56 N0.3 P2400_CMYK

The students usually learn acupuncture for the initial purpose of solving their own health problems. Students are predominantly middle-aged men. About 60 percent of them have health problems of themselves or family members who are suffering from various difficulties.[5] By learning basic oriental medicine alongside acupuncture and moxibustion therapies and by practicing on themselves, they gain experience of their own bodies and health practices. One student acupuncturist told of recovering her health:

> Separated from my family since my high-school days, I had been suffered from various symptoms over ten years, such as myofascial pain, severe cold, acute stomach upset, nephritis, neck pulpusus-disc and migraine. . . . After I practiced moxibustion for two years, I became a healthy woman. There's no more myofascial pain at all now. I don't know how to express this wonderful joy. I stopped using a cataplasm and antiphlogistic one and half years ago. . . . I don't get colds. I can enjoy my favorite food, like noodles, since it doesn't cause stomach pain. If I feel something wrong with my body, I am prepared to apply moxibustion to the right spots, depending on symptoms. The stubborn migraine and menstrual pain also went away permanently. . . . I expelled all diseases from every corner of my body; that is, I cured myself (Jeon M. 2009).

This woman was young, but had a long history of help-seeking for diverse symptoms. Her bodily experiences of painful illness were not fully recognized and treated by hospitals and clinics. By removing symptoms one by one, she rediscovered her body and health. By treating family member's symptoms, she gained regard as "good wife" and "good daughter-in-law." Learning moxibustion helped her experience self-healing, and helped her feel that she has the knowledge to control her own body. At earlier stages of learning, she followed standard moxibustion practices, but has since discovered how to customize her treatment. She came to distinguish her bodily symp-

5. Unpublished statistics provided by the Lovers of Acupuncture and Moxibustion.

www.kci.go.kr

3(Byong-Hee CHO) 2009.10.15 8:23 페이지57 N0.3 P2400_CMYK

toms and apply her own version of moxibustion knowledge.

This process of personal bodily experience of illness and healing and of making personalized pragmatic knowledge is one of the distinguishing features of CAM. The experiential knowledge is strengthened when people exchange knowledge which is then validated intersubjectively (O'Conner 2000). When they become healthy, lay acupuncturists usually recommend their relatives or friends to use acupuncture, or they get start volunteering and practicing on others. They share their knowledge by participating in volunteer care services. In 2008, graduates of the Kim's acupuncture school treated some 142,000 persons with moxibustion in voluntary services (Lovers of Acupuncture and Moxibustion 2009). The graduates organized local associations, which performed volunteer services in their areas of residence. Some graduates utilized the Internet to diffuse knowledge. One graduate said:

> I opened an internet café in 2008 for the purpose of promoting mutual friendship with my classmates. But ordinary people wanted to join the café. Currently, there are more than 2,000 members. I changed my aims to more actively inform people about acupuncture. Now, many people upload their success stories to the café. . . . I am proud of acupuncture and moxibustion (Lee G. 2009).

Very few students intend to care for others when they first start to learn acupuncture. However, the experience of acupuncture encourages them to share knowledge with others. They may not have postmodern values of wellness, but they want to be healthy. They are satisfied with the fact that their health conditions improved through self care by means of a simple technique. They willingly diffuse their own knowledge of acupuncture and moxibustion to others, while the formal medical profession usually refuses to acknowledge the importance collectively experienced lay knowledge (O'Connor 2000).

The popular health movement has been very successful, but acupuncturists like Kim had a price to pay for the popularization of acupuncture. OMDs accused him of violating medical laws in 2009, resulting in Kim being convicted of practicing with only an acupunc-

www.kci.go.kr

3(Byong-Hee CHO) 2009.10.15 8:23 페이지58 N0.3 P2400 _CMYK

ture license, which did not cover moxibustion therapies.[6] However, he practiced moxibustion as well as acupuncture for more than 60 years, the unlicensed practice of which formed the basis of the legal complaint against him. OMDs also made formal complaints to the prosecution against an ordinary housewife who practiced moxibustion on her husband. She was also convicted. She said:

> Moxibustion is a folk therapy inherited from our ancestors. It is absurd to crack down on the practice of moxibustion for family members. . . . Why does the government regulate the people's right to healthy living? . . . I asked the prosecutor why I was guilty. He replied that practicing moxibustion on one's own body was potentially dangerous to oneself, but strictly speaking. However practicing it on other people, including family members, violates the law. . . . If OMDs make a complaint, legal steps must follow.[7]

It was a very surprising affair, because the conviction meant that even self care and knowledge sharing without financial gain is illegal. A National Assembly member prepared a law revision titled the Act for Legalizing Unrestricted Moxibustion Practice. Mass media expressed a great deal of interest in the matter. OMDs maintained that practicing moxibustion requires professional knowledge since it may produce severe side effects, and argued that the new act would threaten people's health.

The success of OMD's in their legal attempts to dampen non-professional CAM practice was closely tied to conservativism inherent in the Korean judicial system. Hwang Jong-Koog, a judge and CAM activist, criticized the legal restriction of popular folk therapies (Hwang 2007). Hwang argued the court interpreted the concept of medical

6. The spots of body to apply acupuncture are almost the same as the spots for moxibustion, but acupuncture requires more skills. Acupuncturists learn moxibustion without difficulty, but moxibustion healers might have trouble practicing acupuncture.
7. Kim Yong-han's statement was presented at the Conference for Legalizing Unrestricted Moxibustion Practice, held in the National Assembly Conference Room in December 30, 2008.

www.kci.go.kr

3(Byong-Hee CHO) 2009.10.15 8:23 페이지59 N0.3 P2400_CMYK

practice too broadly. MDs and OMDs usually claim that such therapies are dangerous when not practiced by professionals. Another example of this is tattooing. Unlike most countries where tattoos are made by professional tattoo artists,[8] in Korea it has been defined as a medical procedure that can only be performed legally by licensed MDs. Since MD's do not train in or perform this service, tattoos have been driven underground. Courts have traditionally looked favorably on doctors' arguments, who usually accept OMD arguments that folk therapies are harmful and should be illegal. These claims seem to stem from Kim's popularity, which threatened OMDs' monopoly of oriental medicine. But the court accepted OMD's claim of the potential for harmful effects from popular practice of folk medicine.

An interesting comparison can be made to the situation in Britain. Acupuncture was introduced to Britain in the nineteenth century, but doctors were reluctant to recognize its beneficial effects until recently. British doctors underestimated the value of acupuncture and overemphasized its risks. However, some of the negative attitude toward acupuncture was attributable to worry over the threat it posed to medical interests at a variety of levels (Saks 1995).

Hwang claims who can cure the patients whom doctors cannot treat. Under the current Korean medical and jurisdictional system, unlicensed practitioners with the knowledge of treatment and therapies cannot treat patients legally. Jang Byeong-du, an elderly unlicensed practitioner, successfully treated terminal cancer patients, but was convicted of unlawful practice in 2006. Hundreds of patients treated by Jang appealed to the court for mercy, arguing that Jang used only simple touch and his drug was quite different from customary herbal medicines. Jang never claimed that he was OMD.[9] Again, OMDs claimed that his techniques were a potential health hazard, and the court convicted him.

8. A tattooist played the performance, arguing that he had the privilege of tattooing. But he was arrested immediately. "The Police Booked a Tattooing Artist to Demand the Legalization of Tattooing," *Hankyoreh*, June 23, 2007.
9. For statement of grounds of the final civil appeal, see http://cafe.naver.com/lovelife-jang.cafe.

www.kci.go.kr

3(Byong-Hee CHO) 2009.10.15 8:23 페이지60 N0.3 P2400_CMYK

The Politics of Oriental Medicine

For a long time, OMDs have tried to claim a similar social status to MDs while professionalizing their works and therapies. However, Medical Law enforces strict regulation and division of the domain of each kind of medicine. MDs are supposed to practice only biomedicine, and OMDs restricted to the practice of oriental medicine. This regulation aimed at restricting OMDs' moves toward the realm of biomedicine dates back to the 1950s when oriental medicine was really underdeveloped (Cho 2006). Most OMDs did not have college credentials and practiced in humble clinics. The government established regulations to protect the MDs from the encroachments of other healers. However, these also came to protect the domain of OMDs more than 40 years later from the encroachments of MDs and other healers. Against the MDs' persistent claim for the integration of two medicines, OMDs utilized the legal division as a shelter to protect their domain.

Changing situations in the 2000s has caused some OMDs to reconsider the meaning of these regulations, which restrict further development of oriental medicine. As OMDs professionalize, their domain expands. In diagnosis as well as in research, their work now requires the utilization of modern medical equipments such CT (computed tomography), despite the fact that medical law does not allow them to legally use such equipment. Some oriental medicine hospitals employ an MD to legally be able to use such equipment. However, an oriental medical hospital was convicted of illegal use of a CT in 2004. MDs argued that CT was designed for applying biomedicine, and was not appropriate for oriental medicine. OMDs argued that the CT was simply a machine and they could read the image produced by the machine by applying theories of oriental medicine.[10]

This legal separation is no longer always useful for OMDs, and some argue for changing the system to integrate MDs and OMDs. OMDs have not yet reached consensus on this issue. Some favor the

10. "Only MDs Can Use CT"; "Why Don't OMDs Use CT?," *Medigate News*, April 20, 2005.

www.kci.go.kr

3(Byong-Hee CHO) 2009.10.15 8:23 페이지61 N0.3 P2400_CMYK

integration of the MD and OMD licenses to encourage further professionalization of the field (Jeong Y. 2009), but others who favor a more traditional concept of oriental medicine are reluctant to do so. Ten years before, when OMDs were involved in a struggle to professionalize the field, such conflicts and opinions would have been rare, but a large number of OMDs now favor integration with MDs. OMDs were busy protecting the traditional domain of oriental medicine at the time, but now actively encroach on biomedicine to help develop oriental medicine.

The formal opinion of the OMDs' association on this issue is that OMDs should form the collaborative relationship with MDs. The association believes that MDs and OMDs should practice together, including exchanging diagnosis, making joint efforts to create a treatment plan, and carrying out treatment together. This collaboration requires both MDs and OMDs to have mutual knowledge of each other's fields. Currently, OMDs learn the basic disciplines of biomedicine, but MDs learn almost nothing about oriental medicine. Collaborative practice in general hospitals is increasing slowly, but the majority of MDs still have unfavorable attitudes towards collaboration with OMDs.[11]

Collaborative practice implies MDs' recognition of the effectiveness of oriental medicine and partnership with OMDs. However, MDs' official recognition of oriental medicine and their understanding of the discourses of oriental medicine do not guarantee equal status between MDs and OMDs. In addition to the difficulty of understanding OM discourse, economic and legal restrictions help keep OMDs in a marginal position within the health care division of labor. Resource allocation and customary patients' help-seeking routes favor biomedicine. One OMD, who has researched cancer therapy for more than ten years, told me that he had difficulty recruiting the patients in early stages of cancer, and had to focus on patients in terminal stages. Since herbal medicines are excluded from reimbursement by

11. "Reluctant MDs and Expecting OMDs for the Policy of Extending the Collaboration Practice," *Medigate News*, June 30, 2009.

www.kci.go.kr

3(Byong-Hee CHO) 2009.10.15 8:23 페이지62 N0.3 P2400 _CMYK

National Health Insurance,[12] most cancer patients rely on biomedical hospitals for financial reasons.

While collaboration practice may improve the social status of OMDs, it cannot solve the fundamental problems with restrictions in the health care system. Some young OMDs try to overcome this by becoming an MD. In the past, OMDs thought that the integration of the licensing system would result in the decline of oriental medicine (Seo 2000), since few MDs were interested in practicing oriental medicine. Now, young OMDs seem to believe that becoming an MD expands their capacity to practice oriental medicine. They think that they are able to discuss and compete with MDs in terms of medical knowledge and therapeutics, and are already fully professionalized.

However, the integration of the licensing system is not as easy as expected. The formal policy of MDs about oriental medicine is that the licensing system should be integrated. But this policy seems to be politically offensive rather than really attentive. MDs are usually favorably disposed to acupuncture, but disregard other parts of oriental medicine. MDs were responsible for the introduction of IMS (intramuscular stimulation), a kind of Western acupuncture, to Korean medical practice. However, this move has proven controversial as MDs argue that IMS is different from Korean acupuncture, and constitutes a new method of biomedical treatment. However, OMDs argue that IMS is a kind of acupuncture, and should not be allowed for practice of MDs.[13] It is the reversed version of the CT debate, in which MDs defended it and OMDs offended it. Hundreds of MDs have studied acupuncture at Kim Nam-su's acupuncture school, and come to appreciate its effects despite the fact that they are not allowed to legally practice it. While MDs tend to accept acupuncture, they deny the effects of herbal medicines. In the United States, herbal

12. The NHI only reimburses acupuncture and a very few processed herbal medicines. Most herbal medicines are prepared by traditional methods, like boiling. Since those are not standardized in terms of scientific measures, they are excluded from NHI reimbursement.
13. "Issue Tracking: Is IMS Acupuncture or a New Medical Technique?," *Naeil News*, November 13, 2007.

www.kci.go.kr

3(Byong-Hee CHO) 2009.10.15 8:23 페이지63 N0.3 P2400_CMYK

medicines are usually regarded as health foods, but MDs in Korea object them on the grounds that they can potentially cause serious and harmful side effects.[14] This puts them in strong opposition to the position of OMDs, who have made efforts to prove the effectiveness of herbal medicines through experiments and research. Medical doctors tend to feel that oriental medicine is not effective and unnecessary, while OMDs are more likely to view biomedicine as an enhancement to their practice. Without addressing these kinds of conflicts, it is impossible to integrate the two medical systems.

Conflict between MDs and OMDs often arises over the issue and place of science in their practice, while conflict between OMDs and acupuncturists revolves the around issue of orthodoxy. None of the participants in politics of acupuncture have doubts over its scientific effects. Acupuncture has been tested already in the United States and other Western countries, so many Korean MDs are ready to accept it as a legitimate medical practice. One MD told:

> I am a doctor of ophthalmology. I entered medical school thirty years ago. When I came to learn of Kim's acupuncture, I was surprised with the effectiveness of his burn therapy. I was more surprised by the fact that such therapy has been unknown to medical society for 14 years (Jeon Y. 2009).

This recognition of Kim's therapy offers acupuncturists psychological support, but there were limits and problems for medical doctors supporting alternative therapies further. OMDs have also criticized MDs for illegally incorporating and using acupuncture. Besides issues of legality, orthodoxy is also a focus of conflict between OMDs and acupuncturists. Since the two groups share theories and techniques, distinguishing legitimate practitioners of acupuncture is important in the fight for public status and support. OMDs argue that they are the

14. "Herb Medicines Should Be Undressed—Doctors of Internal Medicine Proclaimed a Total War against OMDs," *Medigate News,* March 1, 2005; "72% of MDs Experienced the Side Effects of Herb Medicines among Their Patients," *Medigate News,* July 29, 2005.

www.kci.go.kr

3(Byong-Hee CHO) 2009.10.15 8:23 페이지64 N0.3 P2400_CMYK

legitimate practitioners of oriental medicine, with a genealogy that stretches back to the "medical bureaucrats" (*uigwan* 醫宮) of the Joseon dynasty, to the "medicine men" (*uisaeng* 醫生) in colonial Korea, through to the current title of OMD (*hanuisa* 漢醫師) (Association of Korean Oriental Medicine 1989). Acupuncturists argue that there were two forms of oriental medicine in the Joseon era and that acupuncturists and herb practitioners were different occupations. In colonial Korea, acupuncturists and "medicine men" were separate, specialized occupations. This division of labor continued until 1962 when the acupuncture system was abolished. They further argue that they are the legitimate inheritors and practitioners of acupuncture (Lovers of Acupuncture and Moxibustion 2002).

It is difficult to determine which argument is more factual. What made this situation more complicated was the arbitrary intervention of the state in traditional medicine. Korea did not have a modern licensing system for health care by the end of the nineteenth century. In 1914, the Japanese colonial government established a modern health care system based on biomedicine, over which medical doctors exercised sovereign authority, although the colonial government also allowed diverse traditional oriental medicine practitioners to continue working as "medicine men," herbal pharmacists, and acupuncturists. The boundaries of these occupations were ambiguous, and therefore both medicine men and herbal pharmacists prepared herb medicines, and may have practiced acupuncture in some cases. Acupuncturists usually practiced acupuncture and moxibustion, but did not deal with herbal remedies. This division of labor has been the fundamental cause of the current conflict between OMDs and acupuncturists.

In 1962, the Park government legally abolished the acupuncturist system. At the time, acupuncture was regarded solely as the domain of acupuncturists, and in 1961, the Supreme Court confirmed that OMDs had no right to practice acupuncture.[15] As the division of oriental medicine was arbitrary, the best solution was to integrate all

15. Supreme Court decision 4292, Haengsang 122 (October 19, 1961).

www.kci.go.kr

3(Byong-Hee CHO) 2009.10.15 8:23 페이지65 NO.3 P2400_CMYK

three related occupations into one group. However, the government chose to simply expel acupuncturists from oriental medicine practice, reasoning that acupuncture and bone setting were unscientific and premodern while allowing similar therapies to continue under the purview of OMDs. After the abolition, however, OMDs began incorporating acupuncture into their own practices. Herbal pharmacists were allowed to become OMDs by taking a qualifying exam, but acupuncturists were not provided the same opportunity. It seems evident that the acupuncture system was introduced and abolished for political reasons rather than on scientific grounds. Acupuncturists were poorly educated and unorganized, and the abolition meant a symbolic modernization by the government, casting off remnants of premodern culture. For medical doctors, it meant the establishment of professional authority by removing unscientific healers. For OMDs, it meant the protection of occupational orthodoxy by breaking off the relationship with acupuncturists. The alliance of government, MDs, and OMDs made possible the abolition of the acupuncturist system.

The context of health care politics has changed dramatically since then. MDs have come to acknowledge the scientific efficacy of acupuncture and to try incorporating it into their own practices. To learn these therapies, they even consult with the very acupuncturists who had been expelled by their predecessors. Popular attitudes favorable to acupuncture is also good news for acupuncturists because popular concern and mass media has brought the issue of acupuncture to the fore. The Roh government's minister of the Department of Health and Social Welfare promoted a plan for legalizing alternative medicine in 2006. Thus, it needs to recognize the appropriate CAM therapies and to set off adequate regulations. This attempt was not successful because of the objection from OMDs[16] and the government's inattention. The government established the bureau for oriental medicine, but no policy on CAM has been formulated.

16. "Medical Groups Opposed the Revision of the Medical Law Promoted by the Government," *Naeil News,* January 25, 2007.

www.kci.go.kr

3(Byong-Hee CHO) 2009.10.15 8:23 페이지66 NO.3 P2400_CMYK

The lack of government policy on CAM is closely related to its overemphasis on high-tech medicine and the industrialization of health care. The government's health policy has been oriented towards providing professional medical services, and is famous for its capital-intensive structure of health service production. High-tech medical equipments, such as CT and MRI, are used at one of the highest rates in the world. Recently, the government tried to push the industrialization of health care, such as inviting foreign patients, allowing capital investment in hospitals, and supporting the development of gene and stem cell therapy. Even oriental medicine receives research and development support. These policies are aimed at making health care a profitable industry (Lee 2008), but government pays little attention to low-tech remedies and low-cost self care.

Unlike Western societies, health care cost containment is not an important issue in Korea. Under this political economy of health care, the government feels no need to look for cheaper alternatives. The World Health Organization has promoted the utilization of CAM by focusing on its cost-effectiveness. CAM may be a way to provide effective and affordable type of health care for the people who are underserved by conventional medicine (WHO Kobe Center 2001). In Korea, acupuncturists argued that acupuncture and moxibustion may be a cost-effective alternative for an aging society (Lovers of Acupuncture and Moxibustion 2002), but politicians and the government are unconcerned.

This market orientation prevails not only in the government and high-tech hospitals, but also in the area of alternative medicine. Since the spiritual CAM in the West is weak or nonexistent in Korea, market competition has been able to take root among a small business providing therapies. Massage is a notable example, long regarded as an exclusive career for the blind. When the Park government abolished alternative medicine in 1962, massage survived legally as a job for the blind. However, massage as a practice has diversified in recent years, and a group of massage healers claimed that the legal monopolization of massage by the blind was unconstitutional. The Constitutional Court decided against the blind masseurs in 2006.

www.kci.go.kr

3(Byong-Hee CHO) 2009.10.15 8:23 페이지67 NO.3 P2400_CMYK

Many of them were upset and protested the decision; some even committed suicides by jumping into the river (*Newsis*, September 18, 2008). The Constitutional Court reversed its decision in 2008.

Conclusion

Korea has a unique history of CAM. Here, oriental medicine has been successfully professionalized, and OMDs have constructed their own institutional health care production system, such as colleges, research institutes, hospitals, and clinics. Highly qualified students go to OM colleges, and the social status of OMDs is comparable to MDs. In the meantime, acupuncture and moxibustion have become folk therapies that are still legally monopolized by OMDs. Acupuncturists attracted popular concern by transforming oriental medicine into a low-tech version of medical knowledge with techniques suitable for self care. These two strategies pursue different goals. OMDs, who have competed with MDs for one hundred years, promote the scientific basis of oriental medicine. Acupuncturists, in competition with OMDs for 50 years, have made efforts to construct a cost-effective and self-actualizing health care system. In a sense, the two approaches show the potential of oriental medicine to develop into the Third Medicine containing elements of both scientific rigor and empowerment for the people.

However, health politics work against oriental medicine's ability to develop such potential. If OMDs accept acupuncturists as fellows and incorporate them and their skills into general OMD practices while allowing them to continue to maintain their principals of knowledge-sharing and self care, they can operate together from a comparative advantage to MDs who have no such popular network of self care. However, the power and prestige gained through occupational monopoly prevents them from considering such strategy. It is also uncertain whether acupuncturists could maintain their current devotion to the principle of self care, if they are allowed to practice legally, and attempt to improve their status in a more akin to that of OMDs.

www.kci.go.kr

3(Byong-Hee CHO) 2009.10.15 8:23 페이지68 NO.3 P2400_CMYK

There are two more factors playing an important role in the future of alternative medicine. The state has been the supporter and protector of professional medicine. If the state acknowledges the significance of postmodern values such as self care and implements health care reform for realizing such values, CAMs will be in a position to develop further. However, considering the current market orientation and for-profit health policies, the future of CAM is not bright and may find itself transformed into marketable goods and services.

The most important roles in the development of CAM can be performed by lay people. Patient and self-help communities are now emerging in the Internet and off-line (Jeong S. 2006). However organizational networking among the individuals seeking self care is not strong yet. The lack of a spiritual movement and of reflexive modernity makes people hesitant to unite seek for health care as noncommodity. An empowered network of individuals interested in self-care is necessary to the continued and future development of CAM in Korea, replacing the previous system of charismatic individual CAM leaders such as Kim Nam-su of the moxibustion movement.

REFERENCES

Astin, J. A. 1998. "Why Patients Use Alternative Medicine: Results of a National Study." *Journal of American Medical Association* 279: 1548-1553.

Association of Korean Oriental Medicine (AKOM). 1989. *The 40 Years of History of the Association of Korean Oriental Medicine.* Seoul: AKOM.

Baer, H. 2004. *Toward an Integrative Medicine: Merging Alternative Therapies with Biomedicine.* Walnut Creek: Altamira Press.

Bakx, K. 1991. "The 'Eclipse' of Folk Medicine in Western Society." *Sociology of Health and Illness* 13.1: 20-38.

Blaxter, M. 2004. *Health.* Cambridge: Polity Press.

Burrows, R., S. Nettleton, and R. Bunton. 1995. "A Sociology and Health Promotion: Health Risk and Consumption under Late Modernism." In *The Sociology of Health Promotion: Critical Analysis of Consumption,*

www.kci.go.kr

3(Byong-Hee CHO) 2009.10.15 8:23 페이지69 NO.3 P2400_CMYK

Lifestyle and Risk, edited by R. Bunton, S. Nettelton, and R. Burrows, 1-9. London: Routledge.

Cant, S. 1996. "From Charismatic Teaching to Professional Training: The Legitimation of Knowledge and the Creation of Trust in Homeopathy and Chiropractic." In *Complementary and Alternative Medicines: Knowledge in Practice*, edited by S. Cant and U. Sharma, 44-65. London: Free Association Books.

Cant, S., and U. Sharma. 1999. *A New Medical Pluralism?: Alternative Medicine, Doctors, Patients and the State*. London: UCL Press.

Cho, Byong-Hee. 2000. "The Politics of Herbal Drugs in Korea." *Social Science & Medicine* 51.4: 505-509.

__________. 2003. "Chimgu yeongyeok-eul dulleossan jeonmunjikgan-ui jipdan galdeung" (Jurisdictional Conflicts among Professions: The Fall and Rise of the Acupuncturist System in the Folk Sector). *Bogeon-gwa sahoe gwahak* (Health and Social Science) 14: 87-126.

__________. 2006. "Saenguihak-gwa hanuihak-ui sahoejeok gwangye—galdeung-gwa tonghap" (Social Relations of Biomedicine and Traditional Korean Medicine: Conflicts and Integration). *Uicheolhak yeongu* (Philosophy of Medicine) 2: 83-110.

Coe, R. M. 1970. *Sociology of Medicine*. New York: McGraw Hill.

Eisenberg, D. M., et al. 1998. "Trends in Alternative Medicine Use in the United States, 1990-1997." *Journal of American Medical Association* 280: 1569-1575.

Freidson, E. 1970. *Profession of Medicine: A Study in the Sociology of Applied Knowledge.* New York: Harper & Row.

Goldner, M. 2004. "Consumption as Activism: An Examination of CAM as Part of the Consumer Movement in Health." In *The Mainstreaming of Complementary and Alternative Medicine Studies in Social Context*, edited by P. Tovey, G. Easthope, and J. Adams, 11-24. London: Routledge.

Goldstein, M. S. 1999. *Alternative Health Care: Medicine, Miracle, or Mirage?* Philadelphia: Temple University Press.

__________. 2000. "The Growing Acceptance of Complementary and Alternative Medicine." In *Handbook of Medical Sociology*, edited by C. E. Bird, P. Conrad, and A. M. Fremont, 284-297. 5th ed. Upper Saddle River, NJ: Prentice Hall.

Hughes, K. 2004. "Health as Individual Responsibility: Possibilities and Personal Struggle." In *The Mainstreaming of Complementary and Alternative Medicine Studies in Social Context*, edited by P. Tovey, G. Easthope, and J. Adams, 24-48. London: Routledge.

www.kci.go.kr

3(Byong-Hee CHO) 2009.10.15 8:23 페이지70 N0.3 P2400_CMYK

Hwang, J. K. 2007. *Uisa-ga mot gochineun hwanja-neun eotteoke hana* (How to Do for the Patients Who Cannot Be Treated by Doctors). Vol. 2. Busan: Uri Munhwa.

Jeon, Se-Il. 2000. *Bowan daeche uihak* (Complementary Alternative Medicine). Seoul: KyeChook.

Jeon, Young-Chul. 2009. “2009 nyeon 1 wol 12 il—daehan minguk uiryosa-e yeoksajeogin nal” (January 12, 2009—A Historical Day of the Korean History of Medicine). *Tmsarang* 57: 16.

Jeon, Mi-Yun. 2009. “Tteum-eul sarang hamyeonseo haengbok mandeulgi” (Loving Moxibustion and Making Happiness). *Tmsarang* 58: 13-15.

Jeong, Seong-Hye. 2006. “Uri nara ollain hwanja gongdongche teukseong-e gwanhan yeongu” (The Study of the Characteristics of On-line Patient Communities in Korea). Master’s thesis, School of Public Health, Seoul National University.

Jeong, You-Kyung. 2009. “Hanuisadeul-ui uiryo irwonhwa damnon-e gwanhan bunseok” (An Analysis of Oriental Medical Doctors’ Discourse on Unification of Biomedicine and Oriental Medicine). Master’s thesis, School of Public Health, Seoul National University.

Kim, J. Y. 2005. “Hybrid Modernity: The Scientific Construction of Korean Medicine in a Global Age.” PhD diss., University of Illinois at Urbana-Champaign.

__________. 2007. “Alternative Medicine’s Encounter with Laboratory Science: the Scientific Construction of Korean Medicine in a Global Age.” *Social Studies of Science* 37: 855-880.

Kim, Nam-su. 2002. *Chimsarang tteumsarang a naesarang* (Loving Acupuncture and Loving Moxibustion). Seoul: Lovers of Acupuncture-Moxibustion.

Korea Health Industry Development Institute (KHIDI). 2008. *Oeguk mit uri nara-ui yusa uiryo unnyeong siltae josa* (A Survey Report on the Present Status of Alternative Medicine in Domestic and Foreign Countries). Seoul: KHIDI.

Korea Institute for Health and Social Affairs (KIHASA). 2001. *Hanguk-ui sahoe jipyo* (Health and Welfare Indicators in Korea). Seoul: KIHASA.

Lee, Gun-Yoo. 2009. “Tteum sarang nae sarang” (I Love Moxibustion). *Tmsarang* 59: 27-29.

Lee, Sang-Il, et al. 1999. “Uri nara gungmin-ui bowan yobeop iyongnyul, iyong biyong-gwa biyong jichul” (Complementary and Alternative Medicine Use in Korea: Prevalence, Pattern of Use, and Out-of-Pocket Expenditure). *Yebang uihak hoeji* (Korean Journal of Preventive Medicine)

www.kci.go.kr

3(Byong-Hee CHO) 2009.10.15 8:23 페이지71 N0.3 P2400_CMYK

32.4: 546-555.

Lee, Sang-Yi, et al. 2008. *Uiryo minyeonghwa nonjaeng-gwa hanguk uiryo-ui mirae* (The Debate on the Privatization of Health Care and the Future of Korean Health Care). Seoul: Mim Publication.

Lee, Woo-Kwan. 1973. *Sunan yeokjeong* (The Sad History of Korean Acupuncture). Seoul: Korea Acupuncture Association.

Lock, M. 1980. *East Asian Medicine in Urban Japan.* Berkeley: University of Berkeley Press.

Lovers of Acupuncture-Moxibustion. 2002. "The Archive for the Policy of Acupuncture and Moxibustion." Unpublished manuscript.

__________. 2009. "Statistics for Ttmsarang Voluntary Care Service." *Tmsarang* 57.10.

Lupton, D. 1995. *The Imperative of Health: Public Health and the Regulated Body*. London: Sage.

Martin, E. 2000. "Flexible Bodies: Science and a New Culture of Health in the US." In *Health, Medicine and Society: Key Theories, Future Agendas*, edited by S. J. Williams, J. Gabe, and M. Calnan, 123-145. London: Routledge.

Nettleton, S., and R. Bunton. 1995. "Sociological Critiques of Health Promotion." In *The Sociology of Health Promotion: Critical Analysis of Consumption, Lifestyle and Risk*, edited by R. Bunton, S. Nettelton, and R. Burrows, 41-59. London: Routledge.

O'Connor, B. 2000. "Conceptions of the Body in Complementary and Alternative Medicine." In *Complmentary and Alternative Medicine: Challenge and Change*, edited by M. Kelner, B. Wellman, B. Pescosolido, and M. Saks, 39-60. Amsterdam: Overseas Publishers Association.

Parsons, T. 1951. *The Social System.* New York: Free Press.

Radley, A. 1994. *Making Sense of Illness: The Social Psychology of Health and Disease*. London: Sage.

Saks, M. 1995. *Professions and the Public Interest: Medical Power, Altruism and Alternative Medicine.* London: Routledge.

__________. 2001. "Alternative Medicine and the Health Care Division of Labour: Present Trends and Future Prospects." *Current Sociology* 49.3: 119-134.

Seo, Hong-Kwan. 2000. "Hanyangbang uiryo irwonhwa—hanuihak-gwa yanguihak-eun mannaya handa" (The Unification of Biomedicine and Oriental Medicine: the Two Medicines Should Meet). In *Hanguk uiryo daenonjaeng* (The Big Debates in Korean Health Care), edited by Lee Jong-Chan, 286-310. Seoul: Sonamu.

www.kci.go.kr

3(Byong-Hee CHO) 2009.10.15 8:23 페이지72 NO.3 P2400_CMYK

Thomas, K. J., J. Carr, L. Westlake, and B. T. Williams. 1991. "Use of Non-orthodox and Conventional Health Care in Great Britain." *British Medical Journal* 302: 207-210.

Turner, B. S. 1996. *The Body and Society: Explorations in Social Theory*. London: Sage.

World Health Organization. 1978. *Alma Ata Declaration*. Geneva: WHO.

World Health Organization Kobe Center. 2001. *Traditional Medicine: Better Science, Policy and Services for Health Development*. Proceedings of a WHO International Symposium at Awaji Island, September 11-13.

www.kci.go.kr