

Update 57

THE REGULATION AND PROFESSIONALIZATION OF CHIROPRACTIC: A CASE STUDY BASED ON THE UK EXPERIENCE

The following are a number of excerpts from a paper very recently published (1) that pertains to the chiropractic profession in the UK. The paper, by researchers from the University of Leeds and Swansea University, draws on research into practitioner associations representing nine CAM modalities in the UK—aromatherapy, Chinese herbal medicine, chiropractic, crystal healing, feng shui, ‘lay’ homeopathy, medical homeopathy, osteopathy, and Radionics. The paper examines the recent wave of professionalization and highlights the contrasting experience of an association of Chinese herbalists seeking statutory self-regulation (SSR) and an association of chiropractors, the British Chiropractic Association (BCA), which was involved in securing SSR for chiropractic.

In the wake of its recent upsurge in popularity in the West, complementary and alternative medicine (CAM) looks set to become “a permanent feature of our cultural landscape”. Much social science research has focused on the burgeoning demand for CAM, variously attributed to dissatisfaction with orthodox medicine, a desire for holistic treatments that value patient experience, the emergence of ‘smart consumers’ seeking self-empowerment through active healthcare decision-making, or seen as symptomatic of an age of cultivated anxiety

Our initial focus is on the way in which the benefits and costs of professionalization are presented by practitioner associations to engender the support of their membership, with particular reference to an association of Chinese herbalists, which actively lobbied for statutory self-regulation (SSR). Here, the question of reduced autonomy for individual practitioners reveals itself as a source of disquiet. **What such reduced autonomy might amount to is considered in the latter part of the paper, in relation to an association of chiropractors that has been instrumental in securing SSR for its membership.** Whilst SSR is seen to centre primarily on standardization, CAM seems intrinsically inimical to this process. The highly personalized nature of many practices, which depend upon situated encounters and practice-based experience, resist codification and assessment against universal criteria.

For many practitioners and their associations, the bitter pill of increased regulation and national unification is considerably sweetened by the prospect of greater status and recognition.

In order to investigate the ways in which knowledge circulates through a variety of practitioner networks, we asked each association to supply us with all the documentation they produce for their membership: newsletters and journals; information about training opportunities, accreditation, and career development; codes of conduct and disciplinary procedures; advertising and promotional literature; etc. Such materials were provided from June 2001 to May 2003. Unlike [Cant and Sharma \(1998, p. 262\)](#), who were struck by the failure of CAM-based associations “to enforce rigid boundaries between internal (private) and external (public) knowledge,” we had to engage in protracted negotiations with many of the associations (e.g. aromatherapy, Chinese herbal medicine, chiropractic, and homeopathy associations), and most of the associations requested anonymity. Far from lacking an appreciation of the need for a public façade, these associations were acutely aware of the risks of adverse publicity. Heightened is one of the most important transformations in the spatiality of CAM knowledge. **Professionalization is first and foremost an attempt to (re)gain control of CAM in public space.**

Once collected and collated, the documents were subject to a content analysis that focused on how each association reflexively presented the modality in question to its membership (in order for practitioners to have a critical awareness of themselves), and how it situated the embodied practice of therapists in relation to regulation and professionalization (in order for practitioners to have a regard for how they conduct themselves). **Of the nine associations studied, the association of chiropractors and the association of Chinese herbalists were most explicitly concerned with putting ‘professionalism’ into practice.** Their contrasting experiences to help elucidate the complexity of this process.

Professionalization accords precisely with the “obligation to know oneself” for the “training of the self by oneself” discussed by [Foucault \(1997, pp. 227 and 208, respectively\)](#). Indeed, the “art of self-government” ([Foucault, 1997, p. 90](#)) ushered in by SSR differs markedly from the climate of “charismatic therapists, who learnt their ‘art’ through apprenticeship... and practiced independently and energetically,” that characterized the original ‘renaissance’ of CAM in the 1970s ([Cant and Sharma, 1996c, p. 157](#)). The current emphasis on consent, limits, scope, and referral often channels professionalization towards the margins of therapeutic practice: to what is shared amongst professions, such as clinical notes; codes of conduct and ethics; and CPD. **Such measures are often seen as expedients on the road to SSR**, being introduced alongside significant organizational restructuring (the unification of disparate associations, creation of a central register of practitioners, establishment of reporting mechanisms for adverse reactions to treatment, etc.). **They are, however, a form of estrangement.**

[Saks \(2000, p. 230\)](#) notes that professionalization typically provides “positive benefits to those involved in terms of enhanced income, status and power, as well as the satisfaction of working in a well-regulated profession.” Whatever the benefits in terms of legitimacy and status, however, professionalization inevitably imposes additional costs, not only in terms of financing new regulatory bodies, but in potentially imposing greater heteronomy with respect to individual practice. In actively promulgating the need for tighter regulation, therefore, most practitioner associations have sought to vindicate their stance by referring to the increased visibility and public scrutiny of the safety and effectiveness of CAM. Indeed, many associations are actively encouraging evidence-based research amongst their membership. **However, given the apparently high levels of patient satisfaction responsible for fuelling the growth of CAM in the first place, placating consumer anxiety should probably be seen as secondary to a (self-propelling) conviction regarding the necessity of pre-emptive action to fend off the imposition of stricter regulation by government agencies.** A forthright statement to this effect appeared in the Newsletter of an association of homeopaths (Autumn 2002): “[It] has been made very clear ... that we are expected to become a more responsible profession and regulate ourselves in an acceptable way. The unspoken bit is of course that if we do not do it for ourselves, it will be done for us!”

Associations typically present professionalization to their members as both a pragmatic necessity—since unprofessional conduct is self-evidently culpable— and a positive strategy, designed to ensure the continued relative autonomy of the modality as well as increased legitimacy for its practitioners. Yet given that truly autonomous professions are increasingly viewed with suspicion, professionalization may deliver patient protection, legal security, increased status, and heightened legitimacy only at the cost of reduced autonomy for individual practitioners.

Given that SSR formalizes the legal rights of practitioners, safeguards against incompetent and unethical practice, and protects the pharmacopoeia, it has been portrayed as helping to preserve the identity of Chinese herbalism, which is currently being eroded with each decision to proscribe individual herbs. Despite the association of Chinese herbalists subscribing to this position, some practitioners fear its consequences in terms of external interference, the bureaucratic need for transparency and accountability, the circumscription of individual practice, and the potential for individual practitioners to be excluded—either financially (since the trappings of professionalism invariably come at a cost) or legally (they may be removed from the register). SSR can also be viewed as undermining the autonomy of Chinese herbal medicine through the dilution of its philosophical base. **Numerous studies suggest that professionalization involves “accommodation to the bio-medical model”** ([Baer et al., 1998, p. 533](#)). Thus, homeopathy has reportedly amended its knowledge base—dispensing with certain philosophical claims and increasing tuition in biomedical theory—in the hope of enhancing legitimacy ([Cant and Sharma,](#)

[1996a](#)); and chiropractic has debated the intelligibility of ‘subluxation,’ both within chiropractic and to other healthcare professionals.

Rather than safeguarding autonomy, professionalization increasingly involves forming contacts with a range of other professionals; especially orthodox healthcare professionals. Although a key attraction of SSR propounded by many practitioner associations is that recognition by the orthodox medical profession establishes the possibility of working within the NHS, some fear that this would amount to co-optation. **Although chiropractors and osteopaths have attained SSR, they have made few inroads into the NHS, continuing to work almost exclusively on a self-employed basis in the private healthcare sector.**

There is, however, both a definite tension and a complex interplay within CAM between standardization, which seemingly implies practitioner heteronomy, and professionalization, which apparently implies autonomy. Standardization typically aims to reinforce and regulate the distinct knowledge and skills base defining any given practice. A standardized training curriculum and the codification of common criteria against which individual practitioners’ competency and safety may be judged are amongst the key factors necessary for distinguishing qualified practitioners from inadequate, incompetent, and potentially unscrupulous, untrained individuals. Whilst standards as such are hardly new, existing procedures are increasingly being formalized, with extensive documentation, accreditation, and disciplinary mechanisms becoming progressively strengthened. Nonetheless, standardization poses particular difficulties within CAM. Any given practice typically consists of diverse, often contested, principles and techniques, frequently deriving from a variable institutional basis. For instance, different training schools have typically evolved their own traditions and interpretations: where some have seen themselves as innovators, others have sought to return to foundational principles, often in response to their perceived diminution within major training establishments. **This underlying plurality is well illustrated by the chiropractic association’s rejection of the ‘international’ paradigm developed by colleges in the United States, since “it is not exactly in tune with the definition of chiropractic as given by the General Chiropractic Council” (Journal, September 2001).** Moreover, where a range of practitioner associations exists (typical of most CAM modalities), there is often considerable divergence with respect to the initial and continuing education and training requirements, and the codes of ethics and conduct to which members must adhere. Thus, the task of forging consensus presents a considerable challenge.

The difficulties stemming from different institutional traditions are ramified by the **personalized nature of most CAM practices. This notwithstanding, regulatory bodies increasingly view practitioners merely as conduits for the effective delivery of recognized forms of treatment, with little room for idiosyncratic variation.** Many practitioner associations subscribe to this logic. The chiropractic association, for example, has attempted to determine the definitive qualities of the chiropractor. A working group, charged with devising an initial list of qualities for subsequent consultation with members, proposed such statements as “chiropractic is gentle” and “chiropractors treat the whole body, not just backs and are able to treat problems of the joints and muscles and their effect on the nervous system” (Journal, January 2001) as unobjectionable ‘markers.’ The aim of the exercise was to create an identifiable brand that, ideally, individual practitioners ought to personify: “The object ... is to arm the subject with a truth it did not know, one that did not reside in it; what is wanted is to make this learned, memorized truth, progressively put into practice, a quasi-subject that reigns supreme in us” ([Foucault, 1997, p. 102](#)). Moreover, “The reason the [chiropractic association] has a logo and a corporate image, and sticks to a rigid set of rules about how it must appear, is because people learn to recognize a logo, and associate it with certain qualities. ... [T]he logo represents quality care—the gold standard for the chiropractic profession” (Promotion Pack). **If the necessity of such an exercise suggests a sense of uncertainty about the practising subject of chiropractic, it also represents a pragmatic form of product differentiation, in view of the fact that chiropractors are not permitted to differentiate themselves on the grounds of ability and efficacy or even specialism and expertise.**

There are also concerns that standardization may lower standards; typically where the compulsory registration entailed by SSR has led to the reduction of the differing standards of a number of pre-existing practitioner associations to a ‘lowest common denominator.’ One chiropractic association

has found itself in the paradoxical position of attempting to maintain higher standards than those required by the regulatory authority. Furthermore, European-wide standards for chiropractic education and practice are viewed in some quarters as having been set too low. European legislation governing the freedom of movement of healthcare professionals (which permits chiropractors from other EU countries to practise in the UK for up to four months per year without registration) has raised similar concerns.

Standardization thus operates largely on the margins of CAM. The often stringent requirements governing many generic aspects of professional conduct are not matched by similar controls over manipulation, herbal prescribing, or even whether a practitioner should treat a patient in the first place. A suitably qualified practitioner is deemed to be able to reach such decisions in an appropriate way. It is difficult, if not impossible, to determine the average number and frequency of sessions of treatments patients should undergo for any particular condition, but practitioners who have been socialized into ethical practice should be able to reach the appropriate judgement. At the same time, tighter regulation of generic skills affects a form of standardization across a given discipline. In this way, the work of practitioners is made transparent, increasing the accountability of practitioners to a broader range of individuals and organizations. Professionalism thus appears to function as the currency of 'integrated' medicine. It allows everything to be exchanged across the decentralized circuits of contemporary healthcare. **Yet in becoming transparent (to consumers, other professionals, and regulators), CAM risks simply becoming commensurate with other healthcare professions. In becoming transparent to all and sundry, CAM risks becoming transparent to itself.**

ASRF Update Editor's comments:

The following concluding remark comes from an accompanying paper (2) that relates to the professionalisation of counselling in the UK -

"Overall, while some counsellors are unambiguously supportive of the professionalisation of counselling through means that include statutory regulation, many of those whose work in the voluntary sector positions them close to the margins of any regulated profession are equivocal. None of those interviewed believes that the professionalisation of counselling can be halted. However, some express a commitment to a way of engaging with others that exceeds any commitment to the particular occupational group to which they belong. The question for them is whether it is possible to combine professional status with inclusive forms of training and qualification, non-hierarchical relationships between clients and practitioners, and forms of accountability that do not capitulate to an external locus of control."

References:

1. Clarke DB, Doel MA, Segrott J. The regulation and professionalization of complementary and alternative medicine in the United Kingdom. *Health & Place* 2004;10:329-338.
2. Bondi L. "A double-edged sword"? The professionalisation of counselling in the United Kingdom. *Health & Place* 2004;10:319-328.