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Opening the Door to Complementary and Alternative Medicine: Self-Regulation in Ontario*

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This paper examines the steps that three complementary and alternative medicine (CAM) groups – naturopaths, acupuncturists/traditional Chinese medicine practitioners, and homeopaths – are taking to achieve statutory self-regulation in the province of Ontario. The regulatory framework created by the Regulated Health Professions Act of 1991 is outlined, and the differing approaches taken by each of the three groups to gain inclusion under its umbrella are compared and contrasted. The paper assesses the influence of current regulatory and socio-political environments, and queries the extent to which the paradigms of health and health care of these different groups can be accommodated in a regulatory regime heavily reliant on the conventional medical model.

I. INTRODUCTION

This article examines the way three different occupational groups of complementary and alternative medicine (CAM) practitioners are responding to the opportunities for self-regulation that were opened up by the government of Ontario when it passed the Regulated Health Professions Act (RHPA) in the early 1990s. The government instituted the RHPA to further two main goals: one, to enhance public protection and choice by subjecting more professions to a standard form of regulation (Health Professions Legislation Review (HPLR) 1989; Bohnen 1994:1), and two, to control mounting health care costs (Best & Glik 2000; Coburn 1999), by, for example, allowing less expensive types of practitioners to provide a wider range of services.

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When the act was promulgated, twenty-three health care professions had been identified by the government's review process as appropriate for self-regulated status under the RHPA. In addition to the already well-established health care professions such as medicine, nursing, and dentistry, several less established groups such as chiropractic, midwifery, and audiology were included. This was a result of the government's decision to open the door to new health occupations and go beyond the monopolistic framework which had previously governed self-regulated health professions (Alder 2001:1).

Today, other health care occupations are seeking to achieve professional self-governance. It is important to understand that self-regulation is embedded in a larger process of professionalization. These occupations believe that self-regulation would achieve two purposes: first, to offer credibility to their therapeutic modalities and thus expand the market for their services, and, second, to provide protection for the public from unqualified, incompetent, or unscrupulous practitioners who are either not well trained or do not treat patients within ethical and practice standards. They see self-regulated status as a key component in the process of professionalization and securing social legitimacy.

We begin by providing an outline of the regulatory framework as part of the professionalization process under which these groups are trying to fit into the health care system. Second, we look at the ways the leaders of three CAM occupations (naturopathy, homeopathy, and acupuncture/traditional Chinese medicine) who are seeking inclusion under the RHPA, are striving to achieve this goal by responding to the framework for regulation established by the government. Third, we examine the ways other groups of health care professionals are reacting to these attempts by the three CAM groups, and analyse the barriers the groups face in their pursuit of self-regulation. Finally, we discuss the implications of self-regulated status for the process of professionalization.

Whether the claims of these CAM groups for professional status will be recognized depends on a number of factors including: (1) the internal systems within the CAM occupations (jurisdiction over expert knowledge and control of work within a group), (2) the reaction of the external system of professions (jurisdictional disputes with already established health care professions), and (3) whether there are existing vacancies within the health care system.

A. FOLLOWING IN THE FOOTSTEPS OF MEDICINE

At the beginning of the twentieth century when medicine was seeking to achieve self-regulated status and to professionalize, it was able to carve a unique place for itself at the top of the healing hierarchy. Medicine shifted to a scientific model, standardized its educational programs, and established itself in university settings (Flexner 1910). Bio-medicine became the dominant form of healing with monopolistic powers accorded to physicians and endorsed by the state. Non-allopathic practitioners were driven out of the field and into an underground status as their knowledge bases and therapeutic practices were discredited (O'Reilly 2000; Porter 1989; Saks 1995, 2000).

Subsequently, medicine succeeded in gaining self-regulation and professional status by establishing colleges and educational institutions, associations, standards of practice, and ethical reviews. All of these helped to stake its claim to jurisdiction over health care and were accomplished with little organized opposition at the time. Today, medicine, and to a lesser degree, nursing and dentistry, occupy the preeminent positions among the health care professions in Western societies. Complementary and alternative medicine groups wishing to professionalize try to follow the same pathway. However, the political, social, and economic environments have changed substantially. A major obstacle to professionalization

is the need to establish jurisdictional control in the face of organized opposition from the dominant health care professions. While medicine set the pattern for professionalizing a health occupation, Abbott (1988) points out that attempts following the medical example may still be unsuccessful in staking a claim to professional status. He argues that success depends on the existence of a vacancy in the health care system or a lack of opposition from strong competitors in the fight for jurisdiction. Chiropractors in Ontario are a good example of a group of health professionals that has succeeded in gaining self-regulated status, but they are still meeting opposition from the medical/scientific community and have yet to achieve full professional legitimacy.[1] For a health occupation today, there is no longer an automatic progression from self-regulatory status to full professional status as was the case for medicine (Blishen 1991). Furthermore, as Beardwood (1999) points out, the autonomy of all health care professions has been reduced and their future status is much less certain. Health care providers are losing control over their work and patients are more independent than ever. These trends raise questions about the implications of becoming self-regulated. While the quest for self-regulated status will force some health occupations to form professional associations, upgrade their educational programs, and supervise their members more strictly, it is not clear whether all these steps will ultimately confer professional legitimacy.

We have chosen, for analysis, three occupations to represent a spectrum of health care modalities in terms of treatment type, organizational cohesiveness, size of membership, degree of public recognition achieved, and current legal status. While all three groups have argued for inclusion in the new legislative regime during the initial review process conducted by the government-appointed Health Professions Legislation Review (HPLR) (HPLR 1989), none were successful (O'Reilly 2000:90–92). They are at different stages in the professionalization process and in their attempts

to gain self-regulated status.

B. DEFINING A PROFESSION

When does a health care occupation become a profession? The literature on professions is far from clear on this point. Trait and functionalist theorists have claimed that a profession is different from an occupation and that it plays a more important and positive role in society. Scholars like Wilensky (1964) and Caplow (1954) have posited specific characteristics such as an association, long training, and ethical standards of practice that must be attributed to a group before it can be considered a profession. There has been little agreement, however, about the precise configuration of traits that are required for a profession (Saks 2000). Functionalists such as Goode (1960) and Barber (1963) argue that a complex body of expertise that is significant for the society is what distinguishes a profession from other groups. This expertise is associated with a collective orientation, meaning that it is applied in a manner that meets the functional needs of the society and/or the relationship between professionals and their clients (Saks 2000). Functionalist scholars maintain that groups which succeed in achieving professional status are awarded superior economic and social status as well as occupational autonomy.

This approach to defining a profession has been criticized as static and paying insufficient attention to conflicts over power and occupational selfinterests that characterize the process of professionalisation. The more recent neo-Weberian perspective places the emphasis on the structural location of professions in society. It also introduces the concept of social closure (Collins 1990) – the effort to eliminate competition by restricting access to a limited group of eligible members and creating a monopolistic market for their services. Using this concept, Macdonald

(1995) defines a profession as an occupation, based on credentials, with a legal monopoly of social and economic opportunities. The process of professionalization is seen to be a political one which takes place in a market-based context. Occupational groups struggle to gain social closure through turf battles between professionalized and professionalizing groups (Saks 1996).

This perspective also has some limitations. It does not fully account for interactions among professional groups, nor does it allow for processes other than exclusion for determining who gains control (Welsh et al. 2002). Another approach has been proposed by Abbott (1988), who points out that professions are organized into a system. He argues for examining the whole system of professions rather than focussing on individual professions in isolation. In his view, the jurisdictional claims made by members of a profession, as they assert their authority and/or strive to gain status, are inextricably linked to the claims of others. Abbott claims that in occupational groups such as the CAM groups examined here, it is the contest over where they will find space for their claims of expertise in the industry that will ultimately determine whether they achieve the status of a profession. In this article, we add an understanding of jurisdictional battles within the three CAM groups to the concept of social closure. Additionally, we present an overview of the government's regulatory structure and the impact of responses to it on competing groups within the total system of health professions.

As we examine the ways in which naturopaths, homeopaths, and acupuncture/traditional Chinese medicine practitioners seek to achieve professional status through the regulatory process, we question: (1) Will they follow the pathway to professionalization established by medicine or will they create a new pattern? (2) To what extent do the particular characteristics of a group influence its ability to achieve social closure and establish jurisdictional boundaries? and (3) How does the current regulatory system in Ontario facilitate or

inhibit the ability of any CAM occupation to bring about social closure?

II. METHODS

The data for this paper derive from two sources. The first is legislation governing regulated health professions in Ontario and reports of governmentappointed bodies on applications for self-regulation. The second source of data is personal interviews with all the leaders of three CAM groups in Ontario: nine naturopaths, seven homeopaths, and eight acupuncture/ traditional Chinese medicine (TCM) practitioners. In hour long, personal interviews, we asked the leaders (identified by organizational positions and by reputation) about their efforts to professionalize. In response, they focussed on the steps they had taken to gain self-regulation. They identified efforts to establish their scope of practice, educational requirements, standards and quality of practice, and research strategies in the pursuit of self-regulating status. All the leaders we approached granted us an interview. We analysed the responses of the leaders (n = 24) using qualitative methods, invoking both inductive and deductive reasoning. The transcripts of each interview were coded independently by four investigators using a constant comparison analysis. The central issues that emerged were identified based on the key concepts used by respondents. We extracted constructs and concepts from the replies to open-ended questions and spontaneous comments, and examined them for similarities and differences. To further organize the data, we then identified underlying themes and categories such as future goals and strategies for moving ahead. We compared the groups along these dimensions (Denzin & Lincoln 1994; Bernard 2000) and these comparisons permitted us to analyze the process of seeking statutory self-regulation within the system of governance in Ontario.

To understand the situations of the three occupations and their varying approaches to self-regulation, we need to sketch the basic components of the statutory framework within which they seek inclusion.

III. THE REGULATORY FRAMEWORK FOR HEALTH CARE PROVIDERS IN ONTARIO

A. REGULATED HEALTH PROFESSIONS

In Canada, regulation of health care providers falls under provincial jurisdiction. While the legislative regimes adopted by individual provinces vary, all provinces have delegated a large measure of power over, and responsibility for, governance, to at least the more accepted health professions. In practical terms, this means that the rules governing the practice of those professions and the institutions that formulate and implement them have the imprimatur of the state, and that the state will support both the enforcement of those rules and the sanctions imposed for their breach (Moran & Wood 1993:23). Such self-regulatory regimes represent a significant interpenetration of public and private institutions (Freeman 2000:547).

Until recently, the dominant model followed by governments was to regulate health care providers by means of either a licensure or certification system, while at the same time leaving certain types of providers unregulated. A *licensure* (exclusive scope of practice) regime means that only licensed members of those professions can provide services that fall within the scope of practice of the particular profession. The governing legislation defines the scope of practice of each regulated profession with varying degrees of specificity (medicine generally being the broadest). This effectively grants members of the profession a monopoly in providing services. Others, even members of other regulated health professions, can only perform acts falling within the exclusive scopes of practice if the acts are

properly delegated to them, or if they are authorized to do so by the terms of some other statute. It is an offense to provide services considered to constitute practicing medicine or one of the other regulated professions without authorization by license to practice, or proper delegation of authority.

Under a *certification* regime, only qualified practitioners can use a designated title. The ''right to title'' or ''reserved title'' indicates that the practitioner employing it has met certain educational and training requirements and is subject to particular ethical standards. It does not mean that only those practitioners can perform a particular service but is meant to act as a form of quality assurance. Both systems, licensure and certification, can and frequently do coexist in a province. Some types of practitioners, such as physicians, dentists, and pharmacists, are granted a license and the exclusive scope of practice that comes with it, while others, such as physiotherapists, may only be granted a right to title. Still other types of health care providers, such as naturopaths in some provinces and acupuncturists in others, may not be regulated by any specific statutory regime but are subject to laws of general application.

In a number of provinces across Canada, existing structures for the regulation of health care providers have come under increasingly critical scrutiny. The upshot of this has been that a new and different model of governance has attracted significant support from government commissions and committees studying the subject (see, e.g., British Columbia. Health Professions Council 2001; Manitoba. Law Reform Commission 1994; and Newfoundland and Labrador 1996:13–14). In Ontario, the minister of Health established the Health Professions Legislation Review (HPLR) in 1982 to recommend a new structure for the governance of self-regulated health professions. One goal of doing so was to move away from a licensure regime with exclusive scopes of practice to one that was more open and less monopolistic.

The review's central premise was that ''[T]he important principle ... is that the sole purpose of professional regulation is to advance and protect the public interest'' (HPLR 1989:9). With that in mind, it identified nine criteria to evaluate which groups should be accorded self-regulated status.[2] It focussed on a number of key questions (ibid.). The first concern was jurisdictional – should the Ministry of Health assume responsibility for regulating the profession? Second, was statutory regulation of the profession necessary – that is, was there a ''significant risk of harm to patients'' and were existing control mechanisms (e.g., monitoring, supervision, and other forms of regulation) sufficient? Third, would regulation of any kind be feasible – was there a body of knowledge that could form the basis for the profession's standards of practice and appropriate Canadian post-secondary training available? Finally, the review body considered whether professional regulation was practical to implement – were there sufficient members, were they amenable to regulatory control, and were they able to favour the public interest over professional self-interest? After lengthy consideration by the review body, the government of Ontario adopted the new regulatory strategy the HPLR recommended. It became the first common law jurisdiction in Canada to end licensure with exclusive scopes of practice in health care. The new model is now embodied in the legislation governing regulated health professions, the Regulated Health Professions Act of 1991.

The act replaced exclusive licences to practice with a system marked by three elements: first, a scope of practice statement for each of the twenty-three regulated health professions, describing what they, *but not they alone*, do. Second, it set out a restrictive list of controlled acts, performance of which is limited to members of specified professions or their authorized delegates (based on the judgment that specialized knowledge and expertise are required to perform these acts without risk to public safety) (RHPA 1991:§ 27). Not every profession included under the

RHPA is authorized to do all, or even most, of the controlled acts, and indeed, some can do none. Finally, there is a harm clause: a catchall to prevent health professionals acting outside their scope of practice and unregulated health care providers from treating or advising people about their health when foreseeable serious physical harm may result (ibid.:§ 30). There are specific exemptions from the prohibition on performing controlled acts, including aboriginal healers and midwives providing traditional services, those who treat a person by prayer or spiritual means, and others (ibid.: §§ 35, 30). In addition, the RHPA and profession-specific statutes regulate the titles that members of various professions may use in connection with their provision of health services. It also prohibits anyone who is not a member of one of the self-regulated groups from identifying him or herself as qualified to practice that profession (see, e.g., ibid.:§ 33; Massage Therapy Act 1991: c. 27, § 7).

The legislation imposes the same general regulatory template on all twenty-three health professions to which it applies, from physicians and dentists to massage therapists. Each of the regulated professions is also the subject of a profession-specific statute outlining its scope of practice, the controlled acts its members can perform (if any), and titles restricted to members. Professional misconduct is defined in both profession-specific regulations and generally applicable provisions of the RHPA.

An example will help to illustrate these points. Medicine, physiotherapy, and chiropractic are among the professions regulated under the RHPA. The scope of practice of each is described differently in their profession-specific statutes. Yet all three are authorized to perform the same controlled act: ‘‘moving the joints of the spine beyond the individual’s usual physiological range of motion using a fast, low amplitude thrust’’ (RHPA 1991:§ 27(2)4). Despite differences in their training, qualifications, and the orientation of their practices, each is identified as an

appropriate provider of this treatment. Conversely, people who are not members of those professions cannot perform that type of treatment unless delegated to do so. The underlying rationale is that the procedure, indeed all the controlled acts, have been judged to carry a significant risk of harm if provided by individuals without the requisite training or supervision.

More than seventy-five groups of health care providers sought inclusion under the RHPA during Ontario's legislative review process in the 1980s (HPLR 1989:2). Twenty-three were ultimately included in the RHPA, which came into force in 1993 (RHPA 1991:§ 11). The statute anticipated that the list of regulated health professions might not remain static, and included a process to deal with requests by other groups seeking self-governing status under its umbrella. It provided for the creation of a government-appointed review body, the Health Professions Regulatory Advisory Council (HPRAC), whose members are appointed by the minister of Health. Their responsibility is to advise the minister on policy matters, including whether currently unregulated health care providers should be regulated (RHPA 1991:§ 11). The minister referred the question of granting self-regulated status to naturopathy, acupuncture, and acupuncture/TCM to HPRAC in 1994. It submitted its reports in 1996. However, the committee's role is only advisory, and no action resulted except that, following a change of government, the minister asked it to reactivate the three referrals and review its earlier findings in 1999 (HPRAC n.d.c). In late 2000, public release of the 1996 reports was authorized (HPRAC 1996a, 1996b). HPRAC anticipated submitting its second set of reports in early 2001 (HPRAC n.d.b), but nothing further has been made public to date.

B. UNREGULATED HEALTH CARE OCCUPATIONS

Not all types of health care services or providers are subject to specific

legislative regulation. When a particular form of health care is not regulated by statute, does not fall within a practice area that has been assigned exclusively to particular professions, and is otherwise lawful, then other individuals can provide it (YCHS 1999:115). In some instances, there may be a system of voluntary self-regulation in place among providers of certain types of health care. Voluntary regulation means that qualifications and activities are controlled and standards are imposed by the group itself, independently of the state. In these instances, the state does not lend its weight to any sanctions such a group may impose. In addition, all health care providers, self-regulated or not, are subject to laws of general application including the Criminal Code, consumer protection legislation where applicable, and laws governing civil matters such as tort and contract.

Next we describe the situation of the three CAM occupations that are the focus of our paper and their place in the current system of health care in Ontario.

IV. STAKING THE CLAIM FOR SELF-REGULATION

A. NATUROPATHY

Naturopaths have been regulated under the Drugless Practitioners Act (DPA) in Ontario since 1925,[3] but they regard this status as unsatisfactory. Unlike massage therapists and chiropractors, who were also originally regulated under that statute, naturopaths failed in their initial bid to ''move up'' to the RHPA. The Health Professions Legislation Review, in its report laying the groundwork for the new act, noted that the government had announced its intention to deregulate naturopathy entirely in the new system. The reason given was that its philosophy of natural healing made the articulation of common standards of practice an impossibility (Ontario. HPLR 1989:10). The government ultimately did not deregulate naturopathy but, instead, continued to regulate naturopaths under the

existing Drugless Practitioners Act, exempted them from the prohibition on performing controlled acts under the RHPA as long as they acted within the scope of their practice under the DPA, and referred the question of their inclusion under the RHPA to HPRAC (the government's advisory committee) for consideration.[4]

Since their initial bid for inclusion was rejected, the leaders of the group have been lobbying and making submissions to HPRAC for self-regulation. The naturopathic leaders we interviewed expressed considerable frustration regarding the years they have spent in this process. They have made several different submissions to HPRAC, which involves a great deal of work and consultation. Several leaders explained the delays by saying that they had not done a good enough job of explaining naturopathy to the government and to the public at large. ''It was clear that they did not know who we were. . . . We know who we are but no one else does and we have to do a better job of getting our message out.''

1. *Characteristics of the Group*

The naturopaths are far better organized and more united than either the homeopaths or the acupuncturists/traditional Chinese medicine practitioners. Nevertheless, the leaders still believed it necessary to encourage more cohesion within the group. During the past two decades, they have worked to build a comprehensive organizational structure that has allowed them to mobilize resources and membership. Recent estimates indicate that presently there are an estimated 270 active practitioners in the province (Hough, Dower & O'Neil 2001). They now have a national organization and provincial associations in seven of the twelve provinces of Canada. The Canadian College of Naturopathic Medicine, the primary educational institution in the country, is located in Ontario and has

experienced significant growth, graduating over one hundred students in the past year. The college currently exerts most of the leadership for the naturopathic group. Despite some recent progress, the provincial and national associations still take a secondary role. While naturopaths are agreed on the desirability of self-regulation, there still appears to be some conflicts among them. The naturopathic leaders expect that agreement within the group will improve as new, better educated, and more numerous graduates begin to assume leadership roles in the group's organizational structure.

B. HOMEOPATHY

Homeopathy is not a regulated health profession in Ontario, nor has the minister of Health referred the question of self-regulation to HPRAC for advice (O'Reilly 2000:92). While homeopaths made submissions to the government during the initial review of the health professions legislation in the 1980s, they were never given serious consideration and homeopathy was not even successful in being placed in the initial, larger group which HPLR was considering for inclusion under the RHPA (O'Reilly 2000). In the past decade, however, homeopathy has experienced a small scale revival in Ontario. They now have an association to which some of the practising homeopaths belong, as well as several competing educational institutions for training practitioners. Some of the leaders believe that homeopathy should become self-regulating. But, in comparison to the naturopaths, there is not the same sense of urgency about attaining this goal, nor is there agreement among all the leaders on this point. One leader told us: ''Some have applied for government regulation but the rest of us have not.'' Another said: ''Regulation is such a distant step.''

1. *Characteristics of the group*

While most of the homeopathic leaders recognize the need to become more cohesive in order to advance their group interests, they have not been able to pursue this strategy and overcome their divisiveness. A leader put it this way: ‘‘Once all of these associations and colleges come together and have a common platform, then the government will listen. Up till now we are working as splinter groups.’’ The various leaders are vying for control of homeopathy, and competition is further dividing the group. One of the leaders explained it this way: ‘‘It is just us three cowboys out here [the three principal leaders in Ontario] corralling off our own territory. We don’t see eye to eye on a lot of things and it is very sad.’’ Since this interview took place, there has been another split in leadership and a fourth leader has emerged. Like the acupuncture/TCM group, reconciliation of the various members seems unlikely in the near future.

C. ACUPUNCTURE/TRADITIONAL CHINESE MEDICINE

Acupuncturists are separately regulated by legislation in three provinces – British Columbia, Alberta, and Quebec (YCHS 1999:140). Until very recently, practitioners of traditional Chinese medicine had not been granted self-regulated status anywhere in Canada. However, British Columbia has now created a combined College of Traditional Chinese Medicine and Acupuncture. This development followed a recommendation from the provincial review body charged with considering whether self-regulating status should be extended to other groups of health care providers (Traditional Chinese Medicine Practitioners and Acupuncturists Regulation, BC Reg 385/2000). In Ontario, performing a procedure on tissue below the skin is a controlled act under the RHPA (1991:§ 27(2)2), which means that only authorized health professionals or their delegates can do so.

However, acupuncture has been specifically exempted by the government from this section of the statute (O Reg 107/96, made under the RHPA) and the result is that acupuncture is an unregulated procedure in the province.

The leaders we interviewed included a mixture of acupuncture specialists, TCM specialists, and practitioners of both acupuncture and TCM. More than one-half of these practitioners were trained in China before coming to Canada. There are many different groups and educational institutions, and communication among them is limited and often acrimonious. There is considerable tension between those who regard acupuncture as a treatment modality and those who consider it based inherently on the precepts and philosophy of TCM. When there are disagreements among a particular group, it is common practice for one of the parties to leave and set up a new educational institution or association with his or her own followers. This makes it difficult to ascertain exactly how many different groups there are at a given time.

Despite requesting regulatory status from the Ontario government for over twenty years through submissions of various kinds, acupuncturists and TCM practitioners have not yet attained self-regulating status. The leaders seem to believe that the government should adopt a single standard of practice for all the different groups and then let those who do not meet the standards work to upgrade their qualifications. They did not indicate an awareness (as the naturopaths did) that they will need to resolve their own differences and propose an agreed-upon standard to the government that can be backed with sanctions. One of the leaders told us: ‘‘We want the profession to be recognized and standardized and put into legal status. . . . We need the medical doctors to recognize the validity of acupuncture and the government to recognize us’’. There were complaints about the lack of response from the government: ‘‘No one tells you what is going on . . . if they kept us apprised there would be a lot more contentment within the profession.’’

In 1996, HPRAC completed its report, which was limited to a consideration of whether acupuncture should be regulated because it posed a risk of harm, and submitted it to the minister of Health (HPRAC 1996a:2). That report was not released publicly until late 2000. Meanwhile, in 1999 following a change of government in Ontario, the minister of Health requested HPRAC to reactivate the acupuncture and acupuncture/TCM referrals. While this request has resulted in a new round of consultations and submissions, there has been no decision released as yet.

1. *Characteristics of the Group*

The greatest challenge for the acupuncture/TCM group is overcoming differences and increasing cohesion amongst themselves. Some of the leaders were aware of this imperative, but recognized that it would be difficult to pursue this strategy. As one leader explained: ''They have to get their act together. Historically, the regulated health professionals like doctors and chiropractors did not get along so well, but they have come to peace with each other and then gotten regulated. The Chinese organizations still have too much infighting.'' This same leader believed it would be necessary for the government to step in and force the various factions to overcome their acrimony: ''I think that eventually some kind of mediator is going to have to come in and try to make some peace. We have to pull together and have a referee.'' With so many different backgrounds and diverse approaches to healing, the contending interests among this group make it unlikely that the leaders will be able to increase the level of cohesion in the near future.

D. SUMMARY

The characteristics of the three groups can be summarized in the following ways.

The naturopaths are the most organized and most cohesive of the three occupations. Both the homeopaths and the Acupuncture/TCM practitioners are divided into competing factions and in the case of the latter group, by discrepant ideas about how their treatments should be administered and who best to provide them. In all three groups there is evidence of internal battles over jurisdictional claims.

In making their claims for the right to self-regulation, the leaders we interviewed highlighted the following issues: their scope of practice, the quality of their education and training, the caliber of their standards of practice, and the level of qualifications required of practitioners, as well as the nature and extent of their research. The activities of the three groups in each of these areas are discussed below.

V. SCOPE OF PRACTICE

A. NATUROPATHS

At the moment, naturopaths practice under the system of governance called ''right to title''.[5] In attempting to move toward self-regulation, they have faced a serious challenge in defining their scope of practice. Indeed, that was one of the minister's specific questions in both the 1994 and 1999 referrals to HPRAC (HPRAC 1996b; n.d.a). It is currently very broad, and overlaps with a number of other specialities encompassing nutrition, acupuncture, diagnosis, herbal medicine, some chiropractic and homeopathy, as well as life-style counseling, all designed to support and stimulate individuals' inherent self-healing processes (HPRAC 1996b:117). As one leader observed: ''It is hard to convey what we actually do. . .. How can we describe who we are when everyone describes it so differently? There is a good understanding of the parts . . . but there is less understanding that there is a

highly trained professional who is a generalist.''

B. HOMEOPATHS

Unlike the naturopaths, the homeopaths work within a clearly defined scope of practice. Homeopathic medicine is based on the principle that ''like cures like'' and treatments consist of remedies based on that philosophy – minute amounts of natural substances – believed to mimic the body's symptoms in order to stimulate the body's own defense system. Homeopathic remedies are used to treat a wide range of conditions, including acute infections, chronic diseases and emotional disorders. While homeopaths are not in the business of diagnosing a specific disease, they see their role as examining the unique pattern of symptoms that each patient brings to them.

C. ACUPUNCTURISTS/TCM PRACTITIONERS

Like the naturopaths, this group has difficulty defining a distinctive scope of practice. Several regulated health professions such as physicians and physiotherapists, as well as naturopaths and some unregulated practitioners, regard acupuncture as falling within their scope of practice (see, e.g., YCHS 1999:113). Underlying the practice of acupuncturists and TCM practitioners is a philosophy of healing that is based on the general idea of a balance of energy. Treatments seek to remove blockages of energy so that it can keep flowing throughout the body. While there is agreement on the general theory of healing, the leaders explained to us that the nature and extent of treatment varies according to how long and where practitioners have trained. Some have a broad scope of practice while others limit their practice to the manipulation of needles. According to one of the leaders: ''The problem is that there is no clearly defined scope of practice.'' Another

problem mentioned by a leader was their concern that ''regulation may have the effect of limiting our scope of practice so that in a case where we can really do ten things to help, we are only allowed to do three.''

D. SUMMARY

For the naturopaths, their overlapping scope of practice makes it difficult to achieve social closure for their speciality and to make distinct jurisdictional claims. The homeopaths have the most clearly defined scope of practice of the three occupations. It would seem that this would give them an advantage but, given their internal jurisdictional battles and fragmentation, it has had little impact. Like the naturopaths, acupuncture/TCM practitioners perform many kinds of treatments which are administered by a variety of health care providers. They, too, will find it hard to achieve social closure.

VI. EDUCATION AND TRAINING

Quality education and training for practitioners has been highlighted as a key requirement for self-regulation (HPLR 1989:9).

A. NATUROPATHS

The Canadian College of Naturopathic Medicine, the only educational institution in Canada for naturopaths, is located in the province of Ontario. It has worked to upgrade its standards and now has an accredited four-year, full-time professional program.[6] The leaders were aware of the necessity for naturopathy to establish its credibility by ensuring high quality training for its practitioners, which includes a background in biology, chemistry, and psychology. Several naturopathic

leaders stressed the importance of strengthening the scientific base of their college as a future goal. Some also talked about the desirability of having a library link to widespread data sources, in order to enrich naturopathic education.

B. HOMEOPATHS

Homeopathic education in Ontario is divided into several competing schools which have diverse opinions about what is an appropriate curriculum, the length of training, and the required standards for graduation. Most of the leaders believe that in the future, homeopathy must strengthen the quality of its educational institutions. Turning out highly qualified, skilled practitioners is seen as a key strategy in the struggle to gain widespread acceptance, respectability, and eventually self-regulating status. A leader said: ‘‘You can’t just allow someone to come off the street with a sign ‘I am a homeopath’ and start treating people.’’ Another voiced the need for accreditation and certification of educational programs: ‘‘As far as I am concerned, first of all we are trying to set up a national certification and then a continental certification with the Council for Homeopathic Certification in the United States. . .. They set quite a high standard and are also the most recognized group in the United States.’’

C. ACUPUNCTURISTS/TCM PRACTITIONERS

Establishing stringent and universal standards for the education of their practitioners was an important priority for the leaders. As one told us: ‘‘Education is very important. The quality of education has been set but it has to be spread out instead of just being in a few institutions.’’ A leader declared: ‘‘There are some really good schools out there but there are also some very shoddy programs. . . . It [acupuncture/TCM] is mushrooming and unfortunately the courses

are getting worse.'' Clearly the leaders did not have one shared concept of how a well-qualified acupuncturist or TCM practitioner should be trained. A leader said: ''If we had a few good colleges offering high standard professional training, we would be in a much better situation. Look at the chiropractors and the naturopaths. With acupuncture and TCM it is totally different.'' Some schools have worked towards establishing comprehensive, high standard, accredited educational programs. Others have sprung up in an ad hoc fashion and in the opinion of the leaders interviewed, have yet to prove themselves. The result is that the level of training is highly variable.

D. SUMMARY

Only the naturopaths have been successful in centralizing and accrediting their educational programme. They have also been the occupation most willing to include a broad range of sciences in their curriculum. This gives their graduates a degree of credibility in the eyes of others such as physicians, other CAM providers, and the public. In this, naturopaths have come closest to emulating the steps that medicine took to upgrade and consolidate the training of physicians. The education and training of the other two occupations suffer from a lack of consistency across schools both in terms of curriculum and in the standards expected of graduates. They have a lot of work to do before they can approach the level of education established by medicine.

VII. STANDARDS AND QUALITY OF PRACTICE

A. NATUROPATHS

The naturopathic leaders believed that the standards of practice followed by their

practitioners protect their patients from harm. On the one hand, they argued that naturopathic medicine uses safe, gentle, non-invasive therapies which maximize the body's inherent self-healing capacity. On the other hand, the leaders asked HPRAC for authorization to perform procedures that are controlled acts under the RHPA, thus implying that they recognized a risk of harm in some of what they do (HPRAC 1996b). Where there is no risk of harm, the case for inclusion under the RHPA is weakened. In light of this, the leaders have to be careful when making their arguments.

To ensure that all naturopathic practitioners are providing a service of the highest quality, the leaders were convinced that naturopathy would have to be included under the RHPA. They believe that their current status (i.e., regulation under the Drugless Practitioners Act) does not give them sufficient authority to effectively enforce a uniform quality of practice. This is a concern to many of the leaders who want to improve the image of naturopathic practitioners.

B. HOMEOPATHS

Most of the leaders expressed confidence in the quality of homeopathic practice. They described their treatments as safe, non-toxic, and non-invasive with minimal side effects. Some, however, qualified these claims by arguing that homeopathy is only safe when it is practiced by people with high standards of training and clinical experience. As one leader put it: ''Homeopathy is safe but it is safe only in the hands of a professional practitioner . . . a person who really knows how to give it, how often to give it, how to combine it, and when to stop giving it.'' A few of the leaders realized that their credibility with government would be enhanced if the homeopaths could agree on a common set of standards and qualifications. The various groups in the province, however, have not yet been able to arrive at a consensus. As one leader said: ''We need to become more unified as a

profession, but we have not made much progress yet''.

C. ACUPUNCTURISTS/TCM PRACTITIONERS

While the leaders of the different groups among TCM doctors and acupuncturists did not agree on how standards of practice should be applied, they all believed that regulation would ensure high standards. At present there are serious difficulties involved in making certain that all their practitioners are delivering high quality care. A leader pointed out that it is impossible to control practice at the present time: ''There are some scary people practicing out there. This is a concern, but part of the problem is that there is no regulation and no clearly defined scope of practice.'' Another argued that ''[t]he shortest and quickest way [to move ahead] is for us to become regulated and then other practitioners who are already regulated under the act would trust us.''

D. SUMMARY

All three groups of leaders expressed the hope that self-regulation will answer the problem of establishing and enforcing agreed upon standards of practice. At present, each group is unable to accomplish this on its own, but without these standards they will have difficulty gaining self-regulated status. Ensuring high standards of practice was a key step in the professionalization of medicine. These CAM occupations have yet to reach the point where they can coalesce internally in order to implement a common set of practice standards across each group.

VIII. RESEARCH

Evidence which validates the effectiveness of its therapies definitely supports the case

of a group seeking self-regulating status.

A. NATUROPATHS

Leaders of the naturopathic group understood that they need more research to demonstrate the safety and efficacy of their practices. They saw it as a necessary step for becoming regulated and achieving professional recognition. A leader argued that: ‘‘We have to better demonstrate our efficacy. We need to do more studies so that we can go to a government policy person and say, this is how we can be integrated into the health care system and save it money.’’ Not all the naturopathic leaders were as enthusiastic about doing scientific research; some were happy to rely on clinical evidence of patient successes, saying that they have been healing patients for a long time and have many successful cases to draw upon. As one leader said, ‘‘I don’t think we need to do double blind studies, but I do think we need more clinical evidence of efficacy and more outcome studies.’’

B. HOMEOPATHY

Research that demonstrates the effectiveness of homeopathy was also mentioned by some of the leaders as a way to improve its status, but there was less emphasis on this than among the naturopaths. The leaders were split on this issue. Some believed that they must continue to develop research and pursue scientific explanations of how homeopathy works. One of the leaders said: ‘‘We need a lot of research. This is absolutely vital for homeopathy because one of the biggest cards for our opponents is that there are not enough double blind studies done on homeopathy to prove its efficacy.’’ Others were convinced that sufficient proof already exists. As one leader put it: ‘‘It is already proven all over the world. There is a two hundred year history of case histories.’’

C. ACUPUNCTURE/TCM PRACTITIONERS

Among this group of leaders, research was not seen as a necessary condition for achieving regulation. Few mention using research on efficacy and costeffectiveness to further their goal. Most believe that there is already ample proof that their therapies work and can save money for the health care system. One leader claimed: ‘‘Its longevity has already proved its efficacy – over 5,000 years! It has been tested on millions, if not billions of people in the world and it is proven daily in my practice.’’ There was no reference, however, to the fact that scientifically acceptable proof could be of critical importance in justifying their requests for regulation. In spite of the fact that there is a growing body of clinical research on acupuncture that demonstrates its efficacy for specific conditions such as pain control (Berman 2001), the leaders did not refer to these studies.

D. SUMMARY

It was only the naturopaths who mentioned the need for scientific research as a means of gaining professional recognition and legitimacy. Homeopathy and acupuncturists/TCM practitioners were content to rely on historical evidence. We have reviewed the statutory framework that applies to self-regulating health professions, the legal status of unregulated practitioners, and the efforts of naturopaths, homeopaths, and acupuncture/TCM practitioners to be included under the RHPA. We now consider the ways in which health professions which have already gained statutory self-regulation have responded to these groups’ efforts to move into the system.

IX. RESPONSES OF THE HEALTH CARE SYSTEM TO CAM GROUPS SEEKING REGULATION

Opening up the possibility of statutory self-regulation to CAM occupations has major implications for the established professions in the health care system. Professions like medicine and nursing, for example, have been successful in achieving social closure for their members. They have also managed to have their claims to expert knowledge recognized, thus granting them a high degree of legitimacy. The incursion of new jurisdictional claims from unregulated practitioners has precipitated defensive responses from professions already included under the umbrella of the RHPA.

Regulated health professions are able to impose limits on unregulated practitioners by enforcing the various prohibitions in the RHPA, either through the offence section of that statute, or by seeking a restraining order from a court (Steinecke 1995). While these provisions are rarely used, they nevertheless shape what unregulated CAM practitioners can and cannot do. Self-regulated bodies can also have considerable influence on government policy.

When questions arise about whether new groups of health care providers ought to become regulated professions, established health professions will frequently enter the fray to claim that the newcomers should not be allowed because, for example, what they do has no basis in science and their training is not sufficiently rigorous. Indeed, arguments used against one profession may be adopted and used by that profession once it has achieved selfregulation to add weight to its claims that others ought not be allowed that status, or that the newcomers' scope of practice ought not overlap with theirs. In British Columbia, for instance, the College of Chiropractors, in its submission to the Health Professions Council on the question of naturopath's scope of practice, stated that naturopaths had

‘‘failed to provide evidence of their training and education to support their request for expanded scope of practice in the area of spinal manipulation’’ (British Columbia. Health Professions Council 1998). It is interesting to note that this is the same kind of criticism physicians had leveled against chiropractors for years.

Other, more indirect possibilities exist for self-regulated health care professions to limit the practices of unregulated practitioners. These include seeking to expand their own profession-specific scope of practice statements in provinces with licensure regimes. In the province of Ontario, they can ask the government to amend the list of controlled acts under the RHPA so that additional health care services can be provided but only by specified regulated health professionals or their delegates. The latter tactic might be coupled with a more aggressive ‘‘incorporationist’’ approach to particular CAM modalities. This would involve accepting them as beneficial health care services but, at the same time, asserting that the dangers inherent in their provision are sufficiently serious that only members of particular regulated health care professions should be permitted to provide them. Such an approach would create serious barriers for CAM occupations attempting to achieve social closure for their therapies and practices.

Health insurance provides another mechanism for controlling entry of CAM occupations into the larger health care system. Decisions about coverage by both public health insurance and private plans significantly affect access to and availability of CAM services. In Canada, all residents are covered by universal public health insurance for ‘‘medically necessary’’ services. The focus of that coverage is on services provided in hospitals or by physicians (Gilmour 2002). While provinces can choose to insure additional types of health care services and practitioners, such coverage varies from province to province. For instance, chiropractic services are insured in many, though not all, provinces; naturopathy

was insured in one (York University Centre for Health Studies 1999), though it has recently fallen victim to government cost cutting. Additional coverage, however, is subject to caps on payments, limitations on the number of services funded, and other conditions (Naylor 1999). Canadians can also purchase private health insurance for services not covered by the public plan. While this operates in a limited sphere, it increasingly includes various forms of CAM, making these services more available to growing numbers of people.

It is apparent, then, that even unregulated practitioners are controlled indirectly, not only through laws but also through other procedures and institutions. These include the statutory powers granted to regulated professions to restrict unauthorized practice and titles, the structure of health insurance systems, as well as institutional policies excluding CAM practitioners from hospitals and other institutional settings. These mechanisms provide opportunities for the health professions that are already established in the system to protect their jurisdictions from CAM occupations and prevent, or at least delay, their acceptance into the government's system of self-regulation.

Additional barriers to achieving self-regulation are inherent in the CAM occupations themselves. Some may not have a sufficient number of members and the resources required in order to establish the necessary infrastructure to supervise the quality of education and practice. A major barrier for homeopaths and acupuncture/TCM practitioners is the lack of cohesion among them. Without a unified voice, it is difficult to formulate the policies required to move forward. Competing schools and associations make it extremely difficult for these occupations to satisfy the requirements for regulation.

X. DISCUSSION

In this paper, we have sketched the regulatory framework in which three CAM occupations are seeking to gain professional status. They see statutory self-regulation (i.e., inclusion under the RHPA) as the key element to full professionalization. The leaders of all three groups made it clear that they want the protection afforded by this form of regulation. What they do not want are special arrangements designed to fit their particular situations. They want to be included along with the twenty-three health professions who have already made it into the ‘‘inner circle.’’

For the three CAM occupations, the benefits of inclusion in the RHPA are clear. Self-regulation backed by the force of law would afford each of the groups a long sought-after status and legitimacy. It would represent state acknowledgment that their services are part of the formal health care system, and also of their skills and qualifications. It would restrict use of designated titles to registered members. Further, although cost constraints and restructuring in health care make expansion of the limited public health insurance coverage that exists to CAM services unlikely, self-regulated status could make these practitioners more acceptable to private insurers, simultaneously increasing demand for and access to their services.

Integral to the regulatory system is a scope of practice statement that is specific for each profession. This would provide a statutory definition of the profession’s expertise that would inform members, other health care providers, insurers, employers, courts, educators, and the public of their recognized practice area. This information would make it easier for consumers to make appropriate choices about the kinds of health care they require. It could also facilitate integration of services delivered by diverse types of providers into the health care system and would delineate the area of practice for which a group’s governing body

would have to develop both standards of practice and the required qualifications and training. Consumers would thus have the assurance of quality and be protected from practitioners who have not met the standards.

It must be remembered, however, that in Ontario, self-regulation no longer carries with it monopoly rights to deliver particular health services – other practitioners may provide the same types of services as well. While the RHPA does restrict the performance of designated controlled acts to practitioners with statutory authorization or their delegates, given the underlying philosophy of enhancing choice, that list was intentionally kept narrow. It is likely to remain so, although it could be expanded where warranted by a risk of significant harm, in order to ensure protection of the public.

The legitimacy that would come with including these groups under the RHPA would be enormous. However, whether self-regulation would benefit practitioners is not the issue. Indeed, one of the reasons Ontario moved away from a licensure regime with exclusive scopes of practice in health care was because it was seen as promoting the private interests of professionals at the expense of the public. In the final analysis, advancing the public interest is the only legitimate justification for delegating state power to the governing bodies of each profession. These bodies are meant to safeguard the public interest, not their members' own interests. How best to do so is not always clear. We have not queried the adequacy of the RHPA regulatory model or whether it has met the two goals of protecting the public while enhancing choice. Public concerns expressed recently about the governance of regulated health professionals point to gaps and deficiencies in existing regulatory mechanisms (see, e.g., Cribb, Daly & Monsebraaten 2001; Daly & Monsebraaten 2001).[7] It is beyond the scope of this article to do more than reference that debate. However, in deciding whether to extend self-regulatory status to other occupations, government has to determine the adequacy of the

regulatory model as well as its appropriateness for these CAM groups. And it must do so in light of the reality that there is growing public demand for and use of various forms of CAM. This factor makes it increasingly urgent that the state devise a regulatory framework that can ensure safety and accountability.

XI. CONCLUSION

In the end, we need to ask what is the relationship between gaining self-regulation and attaining full professional status? In making their case for self-regulation, the three occupations examined here are developing many of the traits associated with being a profession. For example, naturopaths have created a single national organization to speak for them and one training institution with professional accreditation. Nevertheless, these characteristics alone do not make a profession. One of the essential aspects of professional status is that a group is able to achieve social closure for their practices. These occupations, however, are hampered in this respect by lack of internal cohesion, battles over jurisdiction, and the lack of clear vacancies in the health care system for additional professional groups (Abbott 1988). The introduction into the regulatory framework of the notion of nonexclusive ‘‘controlled acts’’ rather than exclusive scopes of practice for each profession with the passage of the RHPA also makes it difficult for CAM occupations to bring about social closure.

The professionalization process that worked for medicine is unlikely to work for CAM occupations. Even if the three CAM occupations succeed in meeting the criteria for self-regulation established by the review and advisory bodies the government has appointed, this will not necessarily confer professional status or lead to full acceptance within the formal health care system. Statutory self-regulation will not provide a monopoly for some of the controlled acts performed

by CAM groups such as acupuncture or spinal manipulation. Nor will it prevent established health professions from trying to discredit the newcomers as demonstrated by recent adverse critiques of chiropractic by some members of the medical profession (see, e.g., Katz 2001). In addition, competition between CAM occupations can stand in the way of any one group achieving the status of a profession. Finally, each CAM occupation suffers from lack of consensus about critical issues such as scope of practice, educational, and practice standards, and the need for scientific research. It is clear that statutory self-regulation is a necessary but not sufficient condition for professional status. Even if the CAM occupations discussed here clear all the hurdles for inclusion under the RHPA, they will still face barriers to attaining professional status.

In conclusion, it is important to recognize that the philosophies and orientations toward health care that characterize these three groups differ fundamentally from those of conventional medicine. However, in seeking to achieve the status of statutory self-regulation that has been applied to mainstream health professions, the leaders are struggling to fit their unique conceptions into a strikingly different paradigm of health and health care. The language and categories they are using to promote their goals are framed by the influence the medical model exerts on the state. They are talking about scope of practice, education, training, standards of practice, and research in ways similar to the medical profession as they strive to meet the criteria originally developed by the government-appointed review body. The question remains as to whether these groups can retain their unique identities while at the same time fitting within the model imposed by the state.

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NOTES

1. In the last decade, the Canadian Memorial Chiropractic College attempted affiliation with at least two Canadian universities. They have been consistently refused on the grounds that they are not sufficiently scientific to be included in an academic setting. Furthermore, a concerted campaign is still being mounted by certain segments of the medical profession to discredit chiropractic treatments (Katz 2001).
2. The nine criteria for statutory self-regulation as identified by HPLR and later adopted by HPRAC are: (1) relevance of the proposed self-regulating group to the Ministry of Health, (2) risk of harm to the public, (3) sufficiency of supervision, (4) alternative regulatory mechanisms, (5) body of knowledge, (6) education requirements for entry to practice, (7) ability to favor public interest,
   (8) likelihood of compliance, and (9) sufficiency of membership size and willingness to contribute (HPLR 1989; HPRAC 1999:32).
3. For a history of the regulation of naturopathy in Ontario, see HPRAC (1996b). Naturopaths are regulated by statute in British Columbia, Saskatchewan, Manitoba, and Alberta (see, generally, York University Centre for Health Studies 1999:110-11).
4. See the Controlled Acts Exemptions, made under the RHPA (1991:§10); and HPRAC (1996b:1).
5. Sanctions are imposed for holding oneself out as a naturopath when not entitled, rather than for use of the restricted title per se (HPRAC 1996b:43-44).
6. The Council on Naturopathic Medical Education is the accrediting agency for naturopathic colleges in North America.
7. The provincial government has commissioned evaluations of the RHPA and the regulatory college's performances (see, e.g., Task Force on Sexual Abuse of Patients 2001; KPMG Consulting LP 2000). HPRAC has also conducted its own review of the Colleges' performance under the RHPA in *Adjusting the Balance: A Review of the Regulated Health Professions Act* (Alder 2001).

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