



How far can complementary and alternative medicine go? The case of chiropractic and homeopathy

Merrijoy Kelner*, Beverly Wellman, Sandy Welsh, Heather Boon

Institute for Human Development Toronto, University of Toronto, Ont., Canada, M5T 3J1

Abstract

This paper examines the efforts of two complementary and alternative occupations, chiropractors and homeopaths, to move from the margins to the mainstream in health care in the province of Ontario. We use a variety of theoretical perspectives to understand how health occupations professionalize: the trait functionalist framework, social closure, the system of professions, and the concept of countervailing powers. The research traces the strategies that the leaders of the two groups are employing, as well as the resources they are able to marshal. These are analyzed within the context of the larger institutional and cultural environment. The data are derived from in-person interviews with 16 leaders (10 chiropractic and 6 homeopathic) identified through professional associations, teaching institutions and informants from the groups. The responses were analyzed with qualitative content analysis. We also used archival materials to document what the leaders were telling us. The data revealed four main strategies: (1) improving the quality of educational programs, (2) elevating standards of practice, (3) developing more peer reviewed research, and (4) increasing group cohesion. Although both groups identified similar strategies, the chiropractors were bolstered by more resources as well as state sanctioned regulation. The efforts of the homeopaths were constrained by scarce resources and the absence of self-regulation. In both cases the lack of strong structural support from government and the established health professions played an important role in limiting what was possible. In the future, it may be to the state's advantage to modify the overall shape of health care to include alternative paradigms of healing along with conventional medical care. Such a shift would put complementary and alternative medicine occupations in a better position to advance professionally and become formal elements of the established health care system.

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Introduction

A number of complementary and alternative medicine (CAM) occupations in Canada are currently seeking to achieve the status of a profession

and procure a place for themselves in the formal health care system (Kelner, Wellman, Boon, & Welsh, 2004). Similar trends are occurring in other countries such as Britain (Allsop & Saks, 2002; Clarke, Doel, & Segrott, 2004), Australia (Carlton & Bensoussan, 2002) and the United States (Goldstein, 2002; Ruggie, 2004). It seems that the time is opportune for the study of these professional projects. As Turner (2004) points out, the monopoly over health care that has been enjoyed by the

*Corresponding author.

E-mail addresses: merrijoy.kelner@utoronto.ca (M. Kelner), bevwell@chass.utoronto.ca (B. Wellman), welsch@chass.utoronto.ca (S. Welsh), heather.boon@utoronto.ca (H. Boon).

profession of medicine in Western society is being challenged by a complex set of global processes. Among these are broad cultural changes such as the growth of consumerism, transformations in the pattern of disease, rising health care costs, increased access to information through the Internet, and new health-related social movements such as CAM.

There are indications that the current Canadian socio-political environment is sympathetic to the ambitions of the more popular CAM occupations to professionalize. We are seeing increasing consumer utilization and demand for CAM services (Berger, 1999; Ramsay, Walker, & Alexander, 1999; Statistics Canada, 2005). The diverse nature of Canada's population means that its citizens are accustomed to using a variety of treatment modalities for their health care. The increase in chronic health problems has created interest in pursuing alternative solutions for these conditions (Kelner & Wellman, 1997). Expectations for freedom of choice in health care are putting pressure on the state to consider more inclusive policies for the formal system (Coburn, 1999). There also seems to be a growing distrust of authority in general. People are questioning the integrity of government, the motives of politicians, the centrality of religion, the expert knowledge of medicine and the accuracy of testing for pharmaceutical drugs.

In addition, there are signs that the medical profession, while still erecting barriers at an institutional level, is relaxing its original resistance to CAM, at least on an informal basis (Smith-Cunnien, 1998). There appears to be genuine consideration of integrating conventional medicine with CAM (Dalen, 2005). Some physicians are adopting alternative approaches and techniques into their own practices (Tataryn & Verhoef, 2001), and medical schools are increasingly incorporating CAM into their teaching programs (Ruedy, Kaufman, & MacLeod, 1999).

Finally, some provincial governments, such as Ontario and British Columbia, have recently adopted a more open and less monopolistic model for the regulation of health professions (Gilmour, Kelner, & Wellman, 2002). This model makes room for non medical groups to seek state-sanctioned regulation and opens the door to CAM occupations that wish to gain official recognition within the existing health care system (Health Professions Legislation Review, 1989; Welsh, Kelner, Wellman, & Boon, 2004). In Ontario, the Health Practitioners Regulatory Advisory Council (HPRAC) is currently

assessing whether non medical groups such as kinesiology and psychotherapy have met the standards required to join the other regulated health care professions.

There are, however, significant structural limitations on what the CAM occupations can accomplish and change. Medical care in Canada is accessible to everyone, regardless of ability to pay, through the public insurance system. In the case of CAM, however, people must pay out of their own pockets. Furthermore, while medical treatments and prescribed drugs are regarded as legitimate tax deductions, the federal government has consistently refused to allow similar deductions for visits to CAM practitioners or use of natural health products.

In the province of Ontario, CAM groups such as traditional Chinese medicine/acupuncture and naturopathy are working to move ahead with the process of professionalizing at the same time as there is concern about rising costs, a growing emphasis on evidence-based medicine, and an ongoing restructuring of the health care system. The government has been taking an increasing role in managing the health care system and the division of labor within it (Beardwood, 1999; Tuohy, 1999).

It is within this institutional and cultural environment that the CAM groups are attempting to professionalize. They are developing strategies and seeking resources in ways that mirror the measures taken earlier by the more established professions such as law and medicine. Yet, this is the twenty-first century, with barriers and opportunities that present new challenges to those seeking professional status.

In this paper, we compare two CAM occupations, chiropractors and homeopaths, that are currently seeking to establish themselves as institutionalized health care professions in the province of Ontario. We chose to focus on these two groups of practitioners because they illustrate different stages of the professionalization process. Among the various CAM groups in Canada, the chiropractors are the farthest along in the process. They are regulated and have been able to develop consistent strategies and solid resources to advance their interests. The homeopaths, on the other hand, are still struggling to develop appropriate strategies and assemble the resources they would require to realize their potential as a profession. In tracking the development of these two CAM occupations, we attempt to answer the following research

questions: (1) To what extent are they implementing strategies and mobilizing the required resources to professionalize? and (2) To what extent does the larger socio-political context influence the process?

Becoming a profession

In framing this work, we found that we needed to use several different perspectives to describe and understand the process: (1) the trait functionalist approach which assesses a group in terms of how many professional traits (such as standards of education) they possess, (2) the concept of social closure which points to the efforts of a group to limit access to a selected few and exclude outsiders through credentialing, certification and developing a group identity, (3) the system of professions perspective which sees each group jockeying with other groups in the system for power and jurisdiction, and (4) the notion of countervailing powers which points to the ways in which groups in the larger society pursue their own interests and try to constrain each other as they struggle for prestige, power, markets and money.

The trait functionalist framework of [Hughes \(1963\)](#), [Larson \(1977\)](#), and [Freidson \(1986\)](#) regards a profession as a socially negotiated status and focuses on the actions people take to become and remain professional. This framework draws attention to strategies for professionalizing such as improving standards of education, upgrading and enforcing standards of clinical practice and establishing uniform ethical codes. It also highlights the need to develop a distinctive scope of practice that can delineate a jurisdictional boundary around the work of an occupation.

The neo-Weberian concept of social closure used by scholars such as [Collins \(1990\)](#), [Witz \(1992\)](#), and [Saks \(2000\)](#) points to the political aspects and power struggles involved in the process of professionalizing. It refers to the strategies employed by a group to limit access to those who have been certified and have gone through the process of credentialing, thus reducing competition by excluding outsiders and monopolizing available opportunities. Another strategy; building a body of peer-reviewed research, helps to justify and solidify their particular identity. The profession of medicine has used all of these methods to great advantage to gain a legally underwritten monopoly and establish its professional sovereignty at the top of the health care hierarchy. In this paper, we use both these long-

standing theoretical frameworks to analyze the extent to which chiropractors and homeopaths are proceeding on the road to professionalizing.

The process of professionalization, however, does not take place in a vacuum. The system of professions used by [Abbott \(1988\)](#), conceptualizes professions as organized into an interacting system in which each competes for power. This perspective draws attention to both internal occupational divisions, and conflicts with other occupations over jurisdiction. It emphasizes that a group cannot occupy a jurisdiction without either finding it vacant or fighting for it ([White, 1970](#)). The treatment of chronic illness has been left as a vacancy by conventional medicine, with its concentration on acute conditions ([Anderson, 2003](#)). But while the growth in chronic illness provides an opportunity for CAM groups, they have only been partially successful in occupying this vacancy. The profession of medicine has been unwilling to cede this boundary without a fight, and CAM occupations have not been able to act in concert to make their claims. Developing a cohesive membership and identity is a key strategy for mobilizing a group to overcome internal divisions as well as overtaking other groups that are competing for jurisdiction.

According to [Macdonald \(1995\)](#), the study of the professions must take into account “the other protagonists in the arena in which the professions are pursuing their goals”(p. 19). [Light \(2000\)](#) conceives of the various protagonists as countervailing powers, each of which has different interests, cultures and goals that are at odds with the others. This concept of countervailing powers places the study of professions within a larger framework of institutional and cultural forces. It posits that one group may achieve dominance by subordinating other groups who, in time, may mobilize to redress the resulting imbalances. The focus is on “the interactions of powerful actors in a field where they are inherently interdependent yet distinct” ([Light, 1995, p. 26](#)). [Halpern \(1992\)](#) and others have argued that analysis also needs to take into account how the different segments within a group contend for dominance and thereby influence the boundaries between it and other occupations and professions.

Methods

In 2004, we conducted personal semi-structured interviews with the leaders of four of the most commonly used CAM occupations in the province

of Ontario: chiropractic, traditional Chinese medicine/acupuncture, naturopathy and homeopathy. These leaders, 34 in total, were identified through their schools and associations. Here, we focus on the data obtained from the leaders of two of these groups: chiropractors (10) and homeopaths(6). The imbalance in numbers reflects the difference in size of the two occupations.

All the leaders agreed to speak with us. The average length of the interviews was one hour although some extended far beyond that. Each interview was audio taped and transcribed. We began by asking the leaders to tell us the steps they were taking to enhance their professional status, followed by how successful they thought they had been, what the opportunities and barriers were for moving ahead, and how they perceived the future development of their group.

The common mode of analysis for this kind of data is qualitative content analysis (Bernard, 2000; Morgan, 1993). Sandelowski (2000) refers to the early stages of this kind of analysis as 'qualitative description'. All transcriptions were entered into a qualitative software program (Richards & Richards, 2001) for coding and analysis. Each of the four members of the research team extracted concepts and constructs from each interview independently and then met regularly to develop consensus on these codes. We identified underlying themes and consistent categories from the data and then compared these across the CAM groups. Through a process of comparing and contrasting, we were able to refine the key ideas conveyed by the leaders. At times it was difficult to decide which actions should be classified as strategies and which constituted resources. In the end, we made our judgements on strategies based on the theoretical concepts discussed in the introduction and our notion of resources based on the conditions required to facilitate or constrain the implementation of these strategies.

In addition, we collected documentary materials from each group, including educational course calendars, mission statements, newsletters, and web pages. This allowed us to explore and examine the extent to which some of the strategies discussed in the interviews coincided with the documents. Analysis moved back and forth between the responses we were obtaining from the leaders and their official documents and statements. Our understanding of the perspectives of the different groups became clearer as this iterative process continued (Hodder, 1998).

Background description: Chiropractors and homeopaths

Chiropractors are the largest group of CAM practitioners (around 3500 in Ontario) and the closest to being considered 'mainstream'. A recent survey of health services indicates that an estimated 11% of Canadians use chiropractic services; much more than any of the other CAM services available (Statistics Canada, 2005). They are one of the few CAM groups to have been granted official self-regulatory status by the government of Ontario and have had their own associations on a provincial and national level for much longer than any of the other CAM groups (Kelner, Hall, & Coulter, 1980) They have one main educational institution, located in Ontario, which has served them from the beginning. The vast majority of Canadian chiropractors have received their training there (Coburn & Biggs, 1986; Coulter, 1981).

Although homeopathy is widely used in many other parts of the world, it has not flourished in Canada, in spite of its earlier popularity at the beginning of the last century (Blisshen, 1991; Boase, 1994; O'Reilly, 2000). During the last decade, however, there has been somewhat of a revival, although it is still a small group. It is hard to determine an exact number since there is no central registry of practitioners. According to a recent national survey, only about 2% of Canadians seek their services (Statistics Canada, 2005). This small group is divided, with several colleges and associations in the province of Ontario. Homeopathy is not regulated and anyone can 'hang out a shingle' and call himself or herself a homeopath. (Cant & Sharma, 1996; Frank, 2002; Shahjahan, 2004).

Findings

We found that the chiropractic and homeopathic leaders were striving to follow similar strategies for professionalizing. While these strategies resemble the ones used by other professions such as the clergy, law and medicine in the past, our findings show that the strategies and resources need to be considered within the larger framework of current cultural and institutional forces.

Strategies

Improving the quality of educational programs

The chiropractic leaders are keenly aware of the importance of continuing to upgrade their training.

They understand that other stakeholders in the system will critically assess their entrance requirements and training programs. The infusion of medical science into their curriculum is an important part of the chiropractors' attempt to win legitimacy (Welsh et al., 2004). Students are required to be familiar with all the basic elements of the biomedical model, even though they are operating from a different health care paradigms which emphasizes the natural healing ability of the body (Canadian Memorial Chiropractic College, 2004; Kelner et al., 1980).

Successful applicants must complete a three year post-secondary education and a background in biomedical subjects is strongly recommended. In the four year program, students are expected to complete a range of biomedical courses such as anatomy, pathology, immunology, and pharmacology, as well as courses in chiropractic theory, diagnosis and clinical practice (Canadian Memorial Chiropractic College, 2006a, 2006b).

According to the leaders, the chiropractors have worked hard to upgrade their standards of education. One leader claimed that: "The educational background of chiropractors today is equal to many doctors" (C30N). After consulting with educational experts, the chiropractors have revamped their curriculum and have adopted the systems model of education that has been used in medical schools for some time. In addition, the chiropractors have just moved to a new college with state of the art teaching facilities and laboratories.

The homeopathic schools also place a heavy emphasis on teaching the basic medical sciences (Ontario College of Homeopathic Medicine, 2001). A leader claimed that: "For me, the homeopathic profession is a medical profession that has a lot of good training in basic sciences and specializes in homeopathic treatment" (H42R). This same educator told us that during the last five years their school has expanded the science curriculum to include subjects such as anatomy, physiology and pathology. The leader of another school emphasized that they have worked to increase their standards and to add a significant clinical portion to their training (H45R). Yet homeopathic education is divided among several competing schools, and as a consequence, there are different views about what is an appropriate curriculum, proper training, and what the standards should be for graduating.

Elevating standards of practice

One of the basic elements of the professionalization process for health practitioners is an agreement among members to establish standards high enough to ensure safe and effective clinical practice. Clinical practice guidelines need to satisfy members of the group as well as other concerned stakeholders. The challenge for both groups in this study is not only to raise clinical standards, but also to ensure that they are uniformly enforced.

The chiropractors are currently focusing on upgrading their guidelines for clinical practice, emulating what is happening in the medical profession in the United States. As a leader reported: "We have just developed what I think are the best clinical guidelines ever. We have been going through this process for three years now and they are at a substantially higher level than we have ever produced before" (C25N). These guidelines have been developed "through consultation with experts and with other stakeholder groups in the system, and represent a concrete effort to interact with people beyond the borders of our own occupation" (C22R). The leaders believe that the guidelines will enhance the ability of their practitioners to deliver evidence-based health care as well as work in an integrated fashion with other health practitioners. The leaders also understand that continuing education is essential for the professional maturity of chiropractors. "One of the things we have been doing is trying to educate the graduate chiropractor more, using videos, distance education, DVDs and CDs" (C27R).

The leaders realize that variations in chiropractic practice are confusing to the public and they are eager to move toward standardized clinical practice. They know, however, that there is still diversity in what chiropractors actually do in their offices with regard to the way they examine, diagnose and treat patients. While the majority of chiropractors have adopted the role of specialists in back problems, a small minority regard this approach as far too narrow, and embrace a wider scope of practice which emphasizes chiropractic philosophy and its focus on the innate healing capacity of the body. This conflict, which has a long history, is often referred to as the difference between 'mixers' and 'straights' (Chapman-Smith, 2000; Villanueva-Russell, 2004). The leaders recognize that this divisiveness makes it hard to maintain a distinctive scope of practice and achieve social closure for the group.

For the homeopathic leaders, establishing a uniformly high standard of practice is a significant problem (Verspoor, 2004). A leader put it this way: “I don’t know if there is a standard in clinical practice to tell you the truth. I think that everybody sort of develops their own” (H48N). This leader mentioned a conflict between classical homeopathy and what is called ‘poly-pharmacy’ or the use of more herbs in a practice and said that practitioners are making their own decisions on how best to practice homeopathy. It is not that the leaders regard high standards of clinical practice as unimportant, but the fragmentation among the homeopaths makes it difficult to establish a group identity and reach agreement about standards. While the leaders can work toward raising the standards of practice in each of their training institutions, they can not ensure consistency or uniformity, especially as there are some practicing homeopaths who are not graduates of any of the schools in Ontario.

Developing research capacity

In the effort to become a full-fledged profession, the chiropractic leaders have put their faith in scientific research. Currently, there are approximately twenty-one journals publishing peer-reviewed research on chiropractics (Chiropractic Resource Organization, 2006). The leaders emphasize the need for rigorous ongoing research using widely accepted, conventional methods to validate the efficacy of their therapies. This comment was typical: “It is something that you have to do, no question. We have to have the research to be accepted properly” (C24N). Several leaders expressed concern that there are not enough experienced chiropractors to do research. As one said: “There is lot of clinical evidence of chiropractic efficacy but not a lot of published evidence, and this is why we believe it is so important for us to invest in chiropractic researchers who will be able to do this” (C22R). A few leaders favor collaboration with other scientists in the academic and research communities in order to obtain more credible evidence. One pointed to a new research project being carried out between family physicians and chiropractors and commented: “I am all a tingle about being more active in the research community” (C26N).

Not all the leaders agree, however, about the purpose of scientific research. One commented: “We have to supply evidence to the same level as everybody else,—not because it is going to auto-

matically mean anything but simply because if you don’t have it, it’s much easier for others to be critical of us” (C29N). While these respondents acknowledge the importance of gathering evidence, they doubt the extent to which it influences policy. They believe that in the end, decisions about the place of chiropractic in the system are essentially political in nature.

Although most of the homeopathic leaders appreciate the importance of peer-reviewed research for their professional project, they feel they are not in a position to do much about it. Research skills are not part of the educational curriculum at any of the homeopathic colleges. And there are only eight peer-reviewed journals on homeopathy according to an online homeopathic source (HomeoWatch, 2006). As one leader told us: “It is something we are still very weak on” (H41R). Another leader reinforced this view: “In homeopathy, research tends to be limited to one area that we call “proving new remedies; in other words, testing our remedies on healthy volunteers” (H46R). The leaders made it clear that there is no planned systematic program of research for homeopathy; most research is undertaken on an individual basis.

Moreover, not all the homeopathic leaders are convinced that scientific research on the efficacy and safety of their therapies is really needed. Some believe that sufficient proof already exists. As one leader argued: “We have over 200 years of proof if you take the time to look at it. It is all there, although not in the form that is generally accepted today. The double blind study does not fare too well in these sorts of trials because our therapies are very individualized” (H46R). These respondents believe that the kind of research that suits the homeopathic paradigm would not be considered sufficiently “scientific” by the more-established professions.

Increasing group cohesion

Abbott (1988) argues that in order to effectively fight for or occupy a territory, an occupation’s members need to agree on what it is they do and how they should go about doing it. Increasing group cohesion is a major way to establish a group’s professional identity, effect social closure and strengthen the ability to negotiate with others in the system.

The chiropractors have spent many years building a solid and extensive organizational structure. They have worked to create provincial, national and international associations with strong links among

and between them. Nevertheless, the group is still not as cohesive as the leaders would like. While most chiropractors in Canada received their training at the Canadian Memorial Chiropractic College and share a common understanding, a small number have been trained at chiropractic colleges abroad. This has caused some differences to emerge. For example, they tend to bring more business-oriented approaches to their practices in Canada. A leader commented, "It is largely an internal problem and we have not done as good a job as we should have or could have" (C29N).

Group cohesion is a major problem for the homeopaths. They have several colleges and professional associations in the province. This limits their ability to define a distinctive scope of practice, achieve social closure, and present a convincing argument for the inclusion of homeopathy in mainstream health care. The homeopaths in Ontario have a history of competition. As one leader commented: "I think the homeopathic profession has done harm to itself in the way they cannot find peace in themselves" (H42R). Another leader said, "In terms of the profession locally, there is no real co-operation. There is still infighting and so on, which is unfortunate" (H46R).

The leaders recognize that this situation needs to be addressed, but have not yet been able to reconcile their differences. As one told us: "Our future all depends on the profession; whether they can cling together, so to speak, and hold homeopathy as the important child, rather than their own interests. That is what the government and others will look at" (H48N).

Resources

It is one thing for an occupation to have intentions and to develop strategies, but it is quite another to possess the resources to realize them. The following section reports on the way the strategies outlined by the chiropractic and homeopathic leaders are facilitated or constrained by the resources available to them.

Resources for improving the quality of education

The chiropractors clearly have more resources than the homeopaths to realize the strategies outlined above. A key resource is adequate funding for education. The chiropractors have recently opened a new campus for which the funding came mainly from their alumni and individual practitioners

across the country (Canadian Memorial Chiropractic College, 2004). Corporations and foundations also joined in the campaign which they hope will eventually raise thirty million dollars. The provincial government only supports chiropractic education with a student tuition assistance program. It does not contribute to the college itself in any way. As a leader pointed out, "Chiropractic education has been excluded from the publicly funded educational system" (C22R). The ability of the chiropractors to finance and build a new college has been instrumental in attracting large numbers of applicants for their program.

The homeopaths receive no assistance from government for the education of their students or for their schools. All the costs are met through high tuition fees and donations from a small group of practitioners. A leader said that, "If our students could get support from the provincial government there would be five times more students." Despite the lack of funding, this leader added, "Our students are lucky because the Board of Governors of this college are committed in terms of money" (H42R). The lack of a critical mass and a unified structure make it difficult to attract students and raise educational standards. This provides a striking example of the ways in which the scarcity of resources limits the homeopaths' ability to employ a key strategy for professionalization.

Resources for elevating standards of practice

The chiropractors perceive themselves to be in a good position to maintain clinical standards for several reasons. According to the most recent academic course calendar, the majority of the faculty (70%) are chiropractors who have attained additional qualifications such as graduate degrees or clinical speciality designations. In addition, students must undergo 1560 hours of clinical supervision by faculty at the college before they can graduate (Canadian Memorial Chiropractic College, 2006a, 2006b). Statutory self-regulation provides an important resource for chiropractors as they strive to elevate standards of practice and ensure consistency. Chiropractors have been included in the twenty-three health professions that have obtained regulated status under the Regulated Health Professions Act (RHPA) in Ontario. Regulation gives them the authority, through their regulatory college, to enforce standards of clinical practice and monitor ethical misconduct.

Homeopaths have more difficulty maintaining clinical standards. The duplication of clinics in the educational institutions means that there is a shortage of appropriate facilities and also few faculty to carry out supervision of homeopathic practice. This has negative consequences for the way graduates practice when they set up their own offices. Furthermore because the homeopaths are still divided and unregulated, the group lacks any official mechanism to monitor what goes on in each individual homeopathic practice or to sanction practitioners who fail to live up to the expected standards.

Resources for developing research capacity

The chiropractors are trying to develop more chiropractic researchers and want to work collaboratively with scientists in the academic community. One of the leaders put it this way, “We feel it is important to develop our own PhDs so that we can do research at universities. We want chiropractors to have the same credentials and background as other researchers in the health care field but it is a slow process. We are sowing the seeds and they will bear fruit later on” (C22R). They have difficulty, however, finding adequate funds. As one leader said, “There has been a steady increase in the number of papers published, but there appears to be less money available for research grants. I am concerned about the future because I just don’t see the funds out there for our researchers” (C27R). Part of the problem is that chiropractors have been refused university affiliation on the grounds that they are not sufficiently scientific. This lack of a university affiliation puts them at a disadvantage when they apply for grants. They have now begun to raise money to fund their own research in response to the growing demand for evidence-based care.

The principal barrier to establishing a research program for homeopathy is money. Research is a costly undertaking and requires a sizeable group of practitioners who are sufficiently committed to the project to raise the necessary funds and do the work. As a leader told us: “To have the luxury of doing research you need leisure time. Most of us are just making ends meet and there is not a lot of government or private money to do research” (H45R). Furthermore, unlike the chiropractors who are developing their own scholars, this group lacks the ability to do their own scientific research.

Resources for increasing group cohesion

Building cohesion among practitioners requires a concerted effort to build community. The chiropractors have done a much better job of developing the required resources. They have built strong organizational alliances among members of their group. As one leader said, “communication is very much part of our strategic plan. Generally speaking, we are lucky because we are a relatively small profession and it is easier to get together and have representation from all of the organizations. This is where that cohesiveness comes from” (C23). This in spite of the fact that on an individual basis, there remain some differences of opinion about the best way to deliver chiropractic care.

The homeopaths, in comparison, have been unable to reconcile their differences and are still divided into competing camps. The conflict-ridden nature of this group presents a serious barrier to their ability to gather resources and centralize their efforts to professionalize. “Our problem is divisiveness because we can’t make a unified effort even though we have tried at times. It has always broken down into factions” (H46R).

Some homeopathic leaders believe that if they could achieve statutory self-regulatory, this would encourage cohesion among them and also permit them to implement a higher standard of practice for everyone: “Homeopathy is still unregulated so you get a hodge podge of different styles and people introducing different modalities into their practice. We don’t tell people how to practice, most probably because it would be unwieldy trying to enforce something like that” (H43N). The current differences (described above) among the chiropractors demonstrate, however, that regulation in itself does not necessarily bring unanimity.

Discussion

The nature of professions

The choice to professionalize has been important for a number of CAM groups in Canada such as the chiropractors and homeopaths. It is useful to note, however, that other CAM occupations like Reiki have not yet made this choice. Those groups who have decided to pursue a professional project have come to understand the defining core characteristics of a profession. These have been identified as “A prolonged specialized training in a body of abstract knowledge, and a collectivity or service orientation”

(Goode 1960, p. 903 as quoted in Freidson, 1988, p. 77). Based on this understanding, they have worked at developing the necessary strategies and resources.

Becoming a profession depends not only on what a given occupation does to achieve its goal but also on the socio-political context in which it operates (Barry, 2006). The interplay between the group, the other health professions, the state, and the public, determines how far an occupation can go in the professionalizing process.

As these two occupations have been striving to become professions, they have been adopting the traditional strategies outlined by trait-functionalist scholars such as Hughes (1963), Larson (1977) and Freidson (1986) in order to negotiate professional status. While the chiropractors and the homeopaths have been employing similar strategies, they function with unequal resources.

On the one hand, the chiropractors, with a longer history and more resources, have had an opportunity to mature professionally. Their entrance standards for faculty and students have risen over time as well as the standards of their licensing examinations. They have developed a number of provincial and national associations that communicate frequently with each other. They have their own regulatory college with which to oversee standards of clinical practice. Finally, they are involved in a broad program of research, some of which is in collaboration with other academic scholars and institutions.

On the other hand, the homeopaths have experienced a different trajectory. While they worked alongside physicians before the changes occasioned by the Flexner report in the 1920s, their popularity diminished strikingly when medicine assumed the dominant role in health care. More recently, they have begun to re-establish themselves as professional health care providers. This has put them at a disadvantage compared to chiropractors. Their strategies to upgrade and standardize their educational programs, clinical practice guidelines and research endeavors have been hampered by fragmentation within the group. Their lack of unity has also created difficulties when trying to negotiate with other interest groups or establish strategic alliances.

To achieve social closure, Collins (1990) and Witz (1992) emphasize the importance of clearly defining boundaries for those who are certified to claim membership in the group, as opposed to outsiders. Developing group cohesion is an essential strategy

for effecting closure. Our findings indicate that the leaders of the chiropractors are working to diminish differences among their practitioners and create a professional identity. Despite some differences among their members about how chiropractic should be practiced, the chiropractors have achieved a clear scope of practice which has allowed them to differentiate their therapeutic approach from other health care providers. By comparison, the homeopaths have been less able to define boundaries around their work. They still have many more divisions among them, and other modalities such as naturopathy make claims that infringe on their scope of practice.

Fitting into the system

As Abbott (1988) points out, both these groups are competing within a larger system of professions. They are struggling to establish themselves in the face of powerful health professions who dominate the existing system. In addition, they must contend with the claims of other CAM groups who also seek to be included in the system. Their struggles to join the mainstream are complicated by internal divisions and the structural context in which these efforts are occurring. The medical and allied professions, the dominant interest groups, have the power to impress the medical paradigm of health care on government, other health care providers, hospital administrators and large segments of the public (Coburn, 1993; Kelner et al., 2004). Indeed, our findings demonstrate that both groups have been continually adding elements of biomedicine to their educational systems, in the hope of gaining some credibility with and acceptance from the medical establishment.

Light's (1995) perspective of countervailing powers helps to explain how the various interest groups in society interact to facilitate or constrain the progress of chiropractors and homeopaths. One important interest group is medicine, which argues that it needs the bulk of the funds designated for health care, and that it would dilute the quality of care if funds were directed to other kinds of treatments. The medical profession also wants to protect the health of its patients and is reluctant to see them exposed to practices that lack scientific proof of efficacy. If medicine can continue to convince government and the public of these arguments, these CAM occupations will be denied adequate financial resources to pursue key strategies.

Other relevant stakeholders with their own interests to pursue, include other CAM occupations such as naturopathy, traditional Chinese medicine/acupuncture and massage therapy. These practitioners would also like to attain professional status. It would make it easier for them to work with other health care providers in settings where integrated care is being provided. They also understand that becoming professionals will add to their status and earning power as well as protecting their patients. Finally, these groups believe that they can contribute to a broader paradigm of healing.

The strategies and resources that the chiropractors and homeopaths have been able to mobilize in their efforts to carve out a professional niche are directly related to the policies pursued by the state. The government of Ontario has the responsibility to protect the health of its citizens. It therefore feels it needs credible evidence of efficacy and safety before it can actively support inclusion of chiropractors and homeopaths in the formal health care system. The government also wishes to avoid conflict with the medical profession. Finally, the government is anxious not to add new costs to a system that is already financially strained. Recognizing these CAM occupations as professionals would lead to demands for inclusion in the public health insurance system and funding of educational institutions.

In the future, it may be to the state's advantage to modify the overall shape of health care to include alternative paradigms of healing along with conventional medical care. Such a shift would put CAM occupations in a better position to advance professionally and become formal elements of the established health care system.

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