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Responses of established healthcare to the professionalization of complementary and alternative medicine in Ontario

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Abstract

This paper examines the reactions of leaders of established health professions in Ontario, Canada to the efforts of selected complementary and alternative (CAM) occupational groups (chiropractors, naturopaths, acupuncture/traditional Chinese doctors, homeopaths and Reiki practitioners) to professionalize. Stakeholder theory provides the framework for analysis of competing interests among the various groups in the healthcare system. The data are derived from personal interviews with 10 formal leaders from medicine, nursing, physiotherapy, clinical nutrition and public health. We conceived of these leaders as one group of stakeholders, with both common and conflicting interests. The findings demonstrate that these stakeholders are reluctant to endorse the professionalization of CAM. They propose a series of strategies to contain the acceptance of CAM groups, such as insisting on scientific evidence of safety and efficacy, resisting integration of CAM with conventional medicine and opposing government support for research and education. These strategies serve to protect the dominant position of medicine and its allied professions, and to maintain existing jurisdictional boundaries within the healthcare system. The popular support for CAM will require that health professional stakeholders continue to address the challenges this poses, and at the same time protect their position at the apex of the healthcare pyramid.

Keywords: Stakeholders; Group interests; Complementary and alternative occupational groups; Established healthcare professions; Countervailing powers; Jurisdictional boundaries

Introduction

Healthcare is always in the midst of change and crises. In the current environment, this is being fueled by high costs, primary care restructuring and inadequate numbers of medical and nursing personnel. These conditions are influencing the ways in which healthcare is currently being delivered (Mechanic, 1996). At the same time, several groups of complementary and alternative medicine (CAM) practitioners are striving to work their way into the formal healthcare system. Their efforts are bringing about a variety of responses from the established healthcare professions. These responses will have a significant impact on the distribution of power within the system.

In addition, the medical profession is being confronted by increasing directives concerning both the context, and more indirectly, the content of the care they deliver (Coburn, Rappolt, & Bourgeault, 1997; McKinlay & Arches, 1985). Medicine's previously established superior status and authority are being questioned both by CAM practitioners and a more informed public (Haug & Lavin, 1983; Fox & Fallows, 2003). Furthermore, some segments of the population are comparing medicine to the more holistic and individualized approach to care reputed to be employed by most CAM practitioners (Goldstein, 1999; Kelner &

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Wellman, 1997; Kelner, 2000). The autonomy of medicine is being questioned at the same time that consumer demand for CAM has grown (Berger, 1999; Ramsay, Walker, & Alexander, 1999; Angus Reid Group, 2000), the number of CAM practitioners has increased (Gilmour, Kelner, & Wellman, 2002), courses on CAM are being included in the curricula of most North American medical schools (Ruedy, Kaufman, & MacLeod, 1999; Wetzel, Eisenberg, & Kaptchuk, 1998) and consumers are searching the Web for reliable information on CAM (Landro, 2003). While there is certainly no consensus among all CAM groups about the desire to achieve professional status (Cant & Sharma, 1995; Saks, 2000; Kelner, Boon, Wellman, & Welsh, 2002), a number of the better organized groups are now working to attain statutory self-regulation, with hopes of ultimately becoming fully integrated into the formal healthcare system (Boon, Welsh, Kelner, & Wellman, 2003; Gilmour et al., 2002; Welsh, Kelner, Wellman, & Boon, 2004). It is the reactions of the medical stakeholders to these challenges that constitute the focus of this paper.

The literature on stakeholders has typically been used to analyze the dynamics of large organizations such as business corporations and governments (see for example Hendry, 2001; Jawahar & McLaughlin, 2001; Bryson, Cunningham, & Lokkesmoe, 2002). It has only rarely been applied to the analysis of health policy or healthcare systems (Dymond, Nix, Rotarius, & Savage, 1995; Eyles et al., 2001). Here we use the stakeholder literature to inform our investigation of stakeholders' perceptions of recent developments in the healthcare system in the province of Ontario, Canada. We analyze how groups within the established healthcare professions are reacting to the recent moves of selected CAM practitioners to seek professional recognition. In previous articles we have outlined the steps that these CAM groups have taken to professionalize (Gilmour et al., 2002; Kelner et al., 2002; Welsh et al., 2004). In this paper we look at the other side of the coin; the responses of the established healthcare professions. We view the medical profession and its allied professions as a major stakeholder group in the system of healthcare, and the CAM groups as challengers to their position at the apex of the healing hierarchy. Although it seems obvious that stakeholders in any system would seek to preserve the 'status quo' and even to enhance their position, in the field of healthcare it is more complicated than it would at first appear.

Stakeholder theory is based on the concept of "stake" or "interest", and stakeholders act in a strategic fashion to influence the system (Freeman, 1984). A stakeholder group can be understood as any group whose members act together in order to promote their common interest (Pross, 1986). They strive to influence those in power to protect or advance their position within a larger, interacting system (Rowley, 1997). In this case, the system is the healthcare system in Ontario which is currently being restructured (Boase, 1994; O'Reilly, 2000). Stakeholder analysis focuses on the interrelations of groups and their impact on policy (Brugha & Varvasovsky, 2000). Faced with a challenge, stakeholders can: (1) facilitate change, (2) work to maintain the 'status quo', or (3) put constraints on change. Which kinds of influence they attempt to exert depends on how they believe their interests will best be served. While the established health professions seek to regulate market conditions to their advantage against competition, the CAM practitioners, who have been working outside the system, are taking steps to gain legitimation by the state and the relevant publics (Boon et al., 2003; Gilmour et al., 2002; Kelner et al., 2002).

Models of stakeholder behaviour

Different models have been proposed for understanding how people come to perceive their own interests and how they come to act on them (Stone, 1996). A widely used model is Pross's (1986) theory of pressure groups which helps to explain how players participate in the policy process. He argues that in order to be effective, groups should be organized, persistent, have an extensive knowledge of substantive issues and policy processes, have financial resources, and a stable membership. While there can be variations in interest between the members of a stakeholder group (Wolfe & Puttler, 2002), it is safe to assume that the established medical professions exhibit all of the characteristics required to be an effective pressure group.

Alford's model (1975) of embedded structural interests competing within the context of a market society offers a broad perspective on the various players within a system and their position in the policy process. He identifies three major interest groups: "professional monopolists" who control the major health resources; "corporate rationalizers" who challenge their power, and "community populations" who seek better healthcare. He also delineates three classes of structural interests: dominant, challenging, and repressed. Dominant structural interests contain the professional monopolizers who are served by the structure of existing social, economic and political institutions. He describes the challenging interests as the corporate rationalizers. They are the politicians, hospital administrators and government health planners. He sees this groups' interests as improving the efficiency and effectiveness of health services and in doing so, posing a challenge to the fundamental interests of professional monopolizers such as the medical profession. The repressed structural interests are those in the community population. In our study, we conceive of these as the CAM occupations

who are supported by widespread public demand (Berger, 1999; Ernst, 2000; Ramsay et al., 1999).

Alford's emphasis on power arises from professional position and the battle for control of key healthcare resources. He characterizes interest groups as reluctant to yield rights and privileges, and resistant to significant restructuring unless they expect it to afford some new benefits. The key difference between dominant and repressed structural interests is the enormous political and organizational energies that must be summoned by repressed groups if they are to overcome the intrinsic disadvantages of their situation.

Consistent with Alford's approach is the framework of countervailing powers outlined by Light (2000). He regards the established health professions as one of several major countervailing powers in society. The other important powers he identifies are: the state (which in Canada is the major payer of health care), patient groups, the medical industrial complex who produce products and services for profit and finally, alternate modalities of healing. These parties, Light (1995) points out, have different interests, cultures and goals that are in tension with each other. Each of these stakeholder groups seeks to fulfill its interests according to its motivation, its level of organization and the extent of its resources. Each attempts to "override, suppress or render as irrrelevant the challenges by others" (p. 27).

The system of professions

In a similar vein, Abbott (1988) has posited that professions are organized into an interacting system in which they compete for power. Professions compete with one another and between themselves and bureaucracies for jurisdiction over work. Abbott (1988) contends that "Control of knowledge and its application means dominating outsiders who attack that control" (p. 2). In his view, the jurisdictional claims made by members of a profession as they assert their authority or strive to gain status, are inextricably linked to the claims of others. Professions grow when there are niches in the system into which they can grow (Burt, 1992). They change when other professions challenge them by threatening their control over particular kinds of work. The success of a profession in occupying a jurisdiction reflects the struggles of its competitors as much as the professions' own efforts. Abbott (1988) sees the history of professions as the history of recurring battles over turf, and the key events in this history are those that create new jurisdictional boundaries or abolish old ones. He agues that a profession "cannot occupy a jurisdiction without either finding it vacant or fighting for it" (p. 86). White (1970) has referred to these opportunities as the filling of vacancy chains.

In the case of healthcare, treating all the health occupations and professions as a system points to the importance of competition between countervailing powers over jurisdiction. Contesting groups such as CAM practitioners can only gain professional legitimacy if they can appropriate healthcare jurisdictions vacated or left unprotected by others. In this struggle, the medical profession still holds the most powerful position. Medicine's claims to scientific knowledge, and the claims of the allied professions that work in conjunction with medicine, have won legal and social recognition and a commanding market position. The incursion of new jurisdictional claims from aspiring CAM groups is bound to force medical stakeholders to protect their interests by confronting these threats and attempting to limit, subordinate or exclude them (Willis, 1989).

Context

The Alford (1975) model helps to explain the current situation in Ontario, where, the provincial government (corporate rationalizers) is taking steps to reorganize the healthcare system to be more inclusive, cost-effective and efficient (O'Reilly, 2000). The medical profession, along with its' allied professions, are the professional monopolizers. The CAM practitioners have previously been repressed, but now, backed by public demand, a number of them want to be included in the system. A few, such as chiropractic and midwifery have already achieved self-regulatory status (Coburn & Biggs, 1986; Bourgeault, 2000), while several others are now aspiring to this status. These demands pose a challenge to the professions who are already part of that system.

Medicine achieved its ascendancy by developing regulatory bodies with statutory authority to impose professional definitions and standards of practice. This served to exclude other kinds of healers from a legitimate role in the healthcare system (Blishen, 1991). Today, the medical profession still retains considerable countervailing power and control within the healthcare system (Clarke, 1996), even though its' professional dominance is being threatened by a number of factors (Starr, 1982) including new contestants vying for professional acceptance. Coburn, Rappolt, Bourgeault and Angus (1999) argue that state involvement in medical health insurance, competition from other health occupations, as well as broader structural changes such as the patients' rights' movement and advancing technology have led to a decline in medical power. They describe it as: "a transition from a medically mediated state control over" the system of health professions' (Abbott, 1998) to more direct state involvement in healthcare and in the healthcare division of labour" (p. 26).

Alongside the medical profession are other health-related professions such as nursing, physiotherapy, and clinical nutritionists. These groups previously operated under the authority of physicians, but are currently striving to increase their own professional autonomy. In terms of Alford's typology of structural interests (1975), they can be categorized as belonging to both the dominant group (medicine) and to the repressed group. While they have an interest in maintaining the professional hegemony of allopathic medicine with which they are associated, they also want to branch out beyond the authority of medicine and establish control over their own work. The nurses straddle both the dominant group and the repressed group and have less to lose from competition from CAM. The other allied professional groups are threatened by competition from CAM practitioners such as chiropractors and naturopaths, and look to the medical establishment to protect them. They thus share with medicine an interest in constraining the CAM practitioners' efforts to professionalize. At the same time, however, they can be seen as a repressed group in relation to medicine and would like to become more independent of them. Fig. 1 illustrates our application of Alford's typology.

Nursing developed as a profession subordinate to medicine and the hospital (Beardwood, 1999). It has been engaged in a long struggle for autonomy and respect but to date, has been able to achieve only a limited political independence. The profession covers a wide variety of functions and there is considerable disagreement among nurses about the nature of their role. Some see their role as including a variety of activities such as health promotion that go beyond the direct care of patients; others prefer to focus solely on the provision of patient care. Significant issues currently facing the nursing profession are the dramatic loss of nursing jobs and the related move toward the "de-skilling" of nurses by hospitals that replace registered nurses with lesser trained nursing staff (Attewell, 1987). At the same time, there are fewer entrants into nursing, creating a serious shortage of qualified nurses. Recent submissions to the government emphasize the desire for a broad range of healthcare activities, extension of the

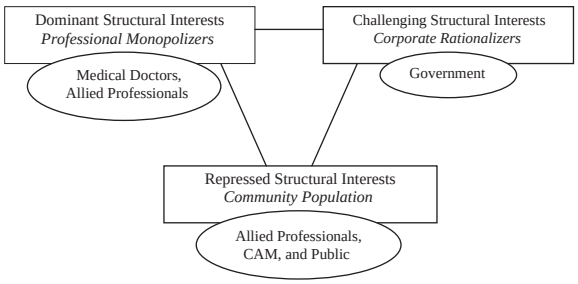

Fig. 1. Application of Alford's typology.

educational requirements for registered nurses, more independent practice, and a focus on the preventive and holistic aspect of healthcare (O'Reilly, 2000).

Physiotherapists and clinical nutritionists are largely dependent upon the medical profession to initiate their services. While most work in general hospitals, increasingly they are employed in other healthcare institutions where they may still work under orders from physicians. Recently, however, these groups have been developing independent clinics where they have primary contact with patients. There is considerable disagreement from physicians about the propriety of such a departure. These various players can be seen as component parts of a larger system of interacting professions, all subordinate to medicine.

Scholars have pointed out that the state plays a critical role in the efforts of aspiring health professions to integrate into the formal system (Angus & Bourgeault, 1999; Tuohy & O'Reilly, 1992). In Canada, where regulation of healthcare providers falls under provincial jurisdiction, the government delegates some of its decision-making authority to the professions through self-regulating bodies which are supposed to act in the public interest. In the early 1990s, the province of Ontario passed the Regulated Health Professions Act (RHPA) with the goal of enhancing public protection and choice in healthcare (O'Reilly 2000). The government wanted to open the door to new health occupations and go beyond the monopolistic framework which had previously governed the self-regulated health professions (Gilmour et al., 2002). A number of CAM groups are now actively petitioning for statutory self-regulation, which they see as a key element in the process of professionalization.

Whether the claims of these CAM groups will be recognized depends on a number of factors including the reactions of the established health professions. Opening up the possibility of statutory self-regulation to CAM groups has major implications for the stakeholders we interviewed. Until recently, they have been able to achieve social closure for their members (Collins, 1990; Macdonald, 1995; Saks, 1999). The incursion of new claims from unregulated practitioners threatens to loosen professional boundaries and change the existing situation.

This study began with the expectation that spokespersons for the established health professions would indicate clear opposition to the claims that a number of CAM groups are making for control over their work and integration into the formal healthcare system. We anticipated that the established health professions would resist any changes in the existing boundaries and would attempt to retain their sovereignty in the face of challenges from groups seeking to occupy a new niche. Our interest was in the kind of arguments they would marshall to express their

opposition and the strategies they would employ to maintain their supremacy.

Methods

Sample

The data for this paper derive from personal interviews with the formal leaders of several established health professions (medicine, nursing, physiotherapy, clinical nutrition and public health; $n = 10$). We selected these particular groups of allied professionals because they are closely associated with medicine, working as insiders in the existing system, and because there is an overlap in their scopes of practice with selected CAM groups. We interviewed the directors or presidents of their professional associations and statutory governing bodies at both the federal and provincial level, in the fall of 2001. All the leaders of the appropriate organizations agreed to be interviewed with the exception of leaders from two of the medical associations, in spite of our repeated efforts. They said that the topic was not relevant to them and they "had no policy addressing these issues". To address this limitation, we have used published policy material from their associations to complement our interview data. We believe that our stakeholder sample is representative of the official stance of the key healthcare professions.

Data gathering and analysis

In these hour long, semi-structured interviews, we asked: (1) whether these stakeholders thought any or all of the following five CAM groups: chiropractic, naturopathy, acupuncture/traditional Chinese medicine, homeopathy and Reiki (selected to represent a spectrum of legitimacy and organizational strength) had a place in the formal healthcare system. If they did not believe these groups belonged in the system, we asked what they would have to do to be included. We also inquired about (2) perceived barriers and opportunities for gaining a legitimate place in the system, as well as (3) the role of government in the professionalization process, and (4) future prospects for integration of conventional medicine with complementary and alternative healthcare.

Our questions were based on the sociological literature on professions and also on our previous research with leaders of the five CAM groups. While the questions covered the core areas of our interests, respondents were encouraged to add their own comments and opinions.

We used the qualitative software program NVivo (Richards, 1999) to analyze the responses of the leaders of the established healthcare professions (medicine, 3; nursing, 3; physiotherapy, 2; public health, 1; clinical dietician, (1). Our aim was to identify key themes and patterns for qualitative description. Sandelowski (2000) has described this form of analysis as especially amenable for answers to questions of relevance to practitioners and policy makers. Each transcript was coded independently by four investigators using constant comparison anaylsis. The central codes that emerged from the interviews were based on the key concerns and perceptions of the respondents. We extracted constructs and concepts from replies to open and closed-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 competition, co-optation and protection of jurisdiction (Bernard, 2000; Denzin & Lincoln, 1994). Since this is an exploratory study with a small sample, we refrain from making generalizations with scientific authority. We can, however, describe and explain how leaders of the established healthcare professions perceive the challenge of CAM occupations attempting to move into mainstream healthcare. We treat the total sample as one stakeholder group but allow for differing and even colliding group interests.

Findings

Stakeholder strategies in response to the challenge of CAM

The data emanating from interviews with this stakeholder group revealed several differences in attitudes. Some of these differences can be explained by the fact that in spite of sharing in the status of allopathic medicine, the roles they play and the authority they enjoy in the healthcare system are not identical (Wolfe & Puttler, 2002). According to official statements of the medical profession, their associations speak only for the interests of physicians and are focused on influencing government in ways that are most favorable to medicine (CMA Web site, 2003; OMA Web site, 2003). The allied health professions share in the high status that medicine enjoys, but not in the power that medicine exerts. They are auxiliary to medicine, and need its protection in order to maintain their position and protect their jurisdictions. The profession of nursing has been subordinated to medicine throughout its history, due to factors such as social class, gender and institutional arrangements (Carpenter, 1993; Coburn, 1988). Today, organized nursing in Ontario has become openly antagonistic to medical interests, demanding an expanded role for nurses in both the hospitals and the community (Coburn et al., 1999). Differences of opinion were evident in the views that the nursing leaders expressed concerning the various CAM groups we asked about. They were more prepared to consider the claims

of the chiropractors and the acupuncturists than the others. While they often answered as if they regarded all CAM groups as one category, they clearly did not see them as a homogeneous entity.

The stakeholder group, as a whole, raised a number of concerns about the professionalization of CAM practitioners. Stemming from these concerns, they outlined a series of strategies for containing the professionalization process.

Number one—insistence on "scientific" evidence of efficacy and safety

Standards of evidence

Most of the stakeholders were unsympathetic to the potential for professionalization of CAM groups. At best, they gave qualified acceptance to the idea that some CAM groups might have a legitimate role to play in the formal healthcare system. They justified their reservations on the basis of the lack of sufficient evidence. They argued that unless a CAM group had a body of knowledge based on 'scientific' evidence and a way of delivering care in an objective, standardized fashion, it was unsafe to allow them to treat patients: "Our role is to assure the public that they have achieved a certain standard" (HP5). This leader indicated his skepticism by adding: "I have not seen any evidence to support that what they do makes a difference—nor have I looked" (HP5). The insistence on valid and reliable evidence of the efficacy and safety of CAM practices and therapies can be viewed as 'the line in the sand' for professional status.

These stakeholders considered higher standards of evidence essential for CAM to gain formal recognition and a place within the formal healthcare system: "I would like to see much higher standards of education based on scientific evidence. The lower standards somewhat diminish the respect we should have for the providers" (HP1). Another leader said: "We would be sympathetic if the way they gained acceptance was based on science—Show me the science that is science as we know it; peer reviewed designs that show it works" (HP8). She believed that some CAM therapies are closer to having convincing evidence than others: "Naturopaths, homeopaths and Reiki, we would have real trouble with; chiropractors and acupuncturists are closer to it—Show me the science, and so far I have not seen the science that has convinced me" (HP8). Another said: "These are new and emerging groups with often little more than anecdotal evidence behind them. That makes it hard for the existing professionals to accept them" (HP7).

Part of the problem is the difference in paradigms between medicine and CAM. Conventional medicine aims to diagnose illness and treat, cure, or alleviate symptoms whereas most CAM disciplines are geared not only to relieve symptoms and restore wellness, but also to help individuals to heal themselves within a holistic approach to health (Zollman & Vickers, 1999). A stakeholder put it this way: "the core of these particular practices, the historical background to them, is quite different than traditional Western medicine and there is significant skepticism and doubt as to whether the claims are valid and approaches that are taken are appropriate and the scopes of practice are legitimate in any sense" (HP3). These stakeholders were reluctant to recognize the value of CAM approaches, arguing that they are grounded in beliefs and traditions that fall outside of the Western scientific model.

These responses show how Alford's "professional monopolizers" can use the argument of unsatisfactory and insufficient evidence to maintain their boundaries and strengthen their superior position. Gieryn (1983) refers to these kinds of arguments as 'ideologies' which serve to justify boundary-work. He cites the example of the sciences, in which efforts to demarcate science from other intellectual activities (non-science) often take the form of attributing selected characteristics to the institution of science. These sorts of statements construct a social boundary that excludes rivals by defining them as outsiders with labels such as 'pseudo', 'deviant' or 'amateur'.

Spokespersons for the nursing associations were more aware of and more sympathetic to CAM versions of evidence than were the other stakeholders:

> I think that when we talk about demonstrating safety and standards and proof, we have to realize that there will be different ways of knowing, different ways of testing the efficacy of these many different practices—not everything can be demonstrated through a randomized clinical trial (HP2)

This belief was shared by a second nursing spokesperson who commented that "There is too much that is unexplained to always look for a scientific rationale for everything" (HP9).

Nurses are more accustomed to using CAM therapies as part of their work. They do this without 'scientific proof' of efficacy, but rather base their use on clinical evidence and experience. This approach is reflected in the mission statement of one of their main associations which acknowledges the value of 'diversity and creativity' in an evolving system of health care. (ONA Web site, 2003).

Standards of education and practice

According to a majority of the stakeholders, the current attempts of CAM groups to upgrade their standards of education and practice must be based on solid evidence. They emphasized that in order for CAM

practitioners to be credentialed, their therapies and practices would have to be evidence-based.

> There is a place for the areas of knowledge and skill they represent. Both the disciplines and those who practice the disciplines have to be credentialed following appropriate training, and their practices have to be approved based on evidence that meets the standards that our society expects (HP1).

One leader admitted that medicine might be imposing a double standard on CAM practitioners: "We are holding them up to different standards than we hold ourselves" (HP10). Another leader pointed out: "We are all struggling with the need to demonstrate safety in an increasingly evidence-based world" (HP3). Even when the established health professions are not able to summon all the necessary clinical evidence for a particular course of treatment, they nevertheless continue to insist that CAM education and practices must be held to the highest standards of evidence.

Self-regulation

The ability to marshall credible evidence of efficacy and safety was also seen by these stakeholders as an essential step in achieving statutory self-regulation for CAM groups.

> If they progress to the point that they meet the standards that we have for our society—and show that they have something beneficial to add and that they are not harmful, then we would agree that they should be self-regulating professions (HP5).

The leaders of the established professions believed that achieving statutory self-regulation would be an important step in the professionalization process, but emphasized that it was a status that had to be earned: "If there is an evidence-based measurement of positive outcome then it would be helpful to patients if they were to become self-regulated" (HP4).

Once again, the question of a double standard for CAM came up. A leader commented: "I suppose one of the things that challenges these new groups is that their organizations will be held to a higher standard of accountability than the traditional groups were when they were first organized" (HP6). Yet, the acknowledgment that this might be the case did not alter their stance.

The nursing professionals more often emphasized the need for public safety and protection, rather than evidence, as a justification for regulating the CAM practitioners: " There has to be assurances that the public is being protected. That is the whole basis of regulation" (HP9). These nursing officials saw possible risks to safety as presenting barriers to professional acceptance. As one said: "If the public is choosing this type of practitioner, they need to know what they are getting—I am very conscious of the public needing to be informed about who their provider is and what they offer and what their limits are" (HP9). For the nursing profession, ensuring patient safety seemed to be more critical than adequate evidence of efficacy. This stance is understandable in view of the fact that nurses spend much of their time with patients and that their mandate emphasizes caring for them.

The leaders of the other allied health professions felt strongly that regulation should not be granted to CAM groups unless they were able to demonstrate in a scientific manner that their therapies were safe and effective and also that their scope of practice was suitable.

> Regulation would have to be based on science. We would certainly also look at whether or not we felt that the scope of practice requested by a group was really appropriate from our perspective. For example, there are lots of groups that claim they can do spinal manipulation but there are only three that are regulated to do so.—That is the kind of thing that if it was in the scope of practice we would have a concern about (HP3).

The issue of scope of practice clearly evoked tensions and concerns about maintaining jurisdictional boundaries and protecting turf among these particular stakeholders.

These findings show the reluctance of the established healthcare professions to encourage the CAM groups in their quest for statutory self-regulation; a critical step in professionalization. The nursing leaders, while more concerned about issues of safety and public protection than 'scientific' evidence, were also unwilling to support self-regulation for CAM.

Number two—redefining integration

As the demand for CAM has grown, and established healthcare providers have taken an interest in some CAM therapies and products, the prospect of integrating conventional medicine with these practices is receiving serious consideration. While there is little consensus on what an integrated system of healthcare would look like, or how it should be operationalized, the basic principle is the use of non-hierarchical interdisciplinary teams that deliver a wide range of treatments blending the best of both conventional medicine and CAM (de Bruyn, 2003; Shuval & Mizrachi, 2002). The stakeholders, in our study, saw this as a distant step which they did not welcome. They proposed several different ways to block or at least control the possibility of integration.

Co-optation

Some saw integration as a process that takes techniques of CAM and delivers them within the conventional system, leaving control in the hands of physicians. This version is really more like incorporation, in which medicine dominates and protects its strategic interests (Saks, 2002). This process is consistent with Larkin's (1983) earlier concept of "occupational imperialism". As one leader said:

> I think that those who are looking at themselves as complementary and alternative practitioners might have to recognize the reality that as things meet the standard and are supported by evidence, they may well be incorporated as part of the practice of conventional practitioners. It is not just a matter of the physician being obstinate about recognizing the autonomy of the complementary and alternative practitioners, but if they truly believe in the value of these things they do for the public, then they should not be opposed to those modalities that are approved being offered by others. If they do know how to do them, they may well incorporate them and then the need for a freestanding practitioner who only offers that, may not be necessary (HP1).

The Ontario medical association has initiated a special section on CAM. This section consists of physicians who are interested in delivering CAM therapies but does not include any non-medical practitioners.

Several of the nursing leaders also indicated an interest in incorporating CAM therapies into their professional role and, indeed, their professional association has an interest group on complementary therapies (NAO Web site, 2003). They saw integration as an opportunity to enlarge the scope of nursing practice. They told us that if CAM groups were to become regulated, many nurses would consider delivering CAM services themselves:

> Nursing is a very large profession and has a wide variety of activities and areas of practice and it wouldn't surprise me that there would be a number of nurses that would be interested (HP2).

A leader claimed that:

> CAM therapies such as Reiki and therapeutic touch can be incorporated into nursing practice and become a nursing intervention. They would have to be diligent about having the competence to practice in that area and would have to have additional education and training to handle the responses. It could be drawn into the scope of nursing practice by using all of those safeguards (HP9).

Another maintained that nurses should be able to perform acupuncture. She added:

> The limitations of Western medicine with chronic illness and terminal illness are quite severe and we see in the nursing community that those areas offer great opportunity for nursing because nursing provides care throughout life (HP6).

These responses suggest that at least some of the nursing profession would be interested in taking over CAM practices rather than referring patients to CAM providers. Some nurses are already incorporating selected CAM therapies such as therapeutic touch into their hospital-based practices.

The leaders of the other allied health professions had given less thought to the notion of integrating CAM with conventional healthcare:

> I would have to say that I have not spent a lot of time thinking about it. We have a very stilted and difficult view of primary healthcare and we haven't sorted out what it is right now, with mainstream frontline providers. To go further down the road to see where natural medicine fits into the middle of all that feels like a leap to me (HP3).

Another said: "It has not been on the radar screen" (HP7).

This tactic of co-optation allows the doctors and the nurses to contain the pressures of public demand for CAM. It increases the scope of their professional roles, permits them to maintain their dominant structural interests and limits the need for the repressed interests (both CAM and the public) to strive for integrated healthcare.

Gatekeeping

Most of the medical leaders argued that physicians need to be the gatekeepers for other kinds of healthcare. Even when they believed that some CAM practices could help patients, they contended that diagnosis of a patient's problem should remain the responsibility of the physician. They justified this position by claiming that it is for the benefit of the patient's overall health and well-being, and argued that only if a physician does the diagnosis, can the patient be assured that his/her condition does not urgently require conventional medical care. In discussing the potential for co-operation between medicine and chiropractic, a medical stakeholder said: "In the area of diagnosis, the diagnosis should be made by a physician, and [then] ongoing treatment by the physician and the chiropractor together would be extremely beneficial for the patient" (HP1). Retaining the right to diagnose patients' problems gives the medical profession control over the work of CAM

practitioners and allows physicians to decide who should treat which kinds of conditions.

The nursing stakeholders took a different view on the issue of gatekeeping. One expressed a preference for a community service type of model for primary healthcare that could replace solo practice and not add extra costs:

> The physician as gate keeper has got to stop. It is a question of cost shifting (rather than increasing costs).—We should conceive of a system that has a number of ways to interact, and you don't get that through solo practice (HP6).

Other nursing leaders also argued that government should reorganize primary care to do away with solo, fee-for-service practice and physicians as gate keepers, and create a more coordinated, holistic system which could offer a range of therapies to the public. With the exception of the nursing leaders, however, the other stakeholders see the tactic of gatekeeping as a legitimate way of protecting their primacy in healthcare.

Resisting team work

Physicians have found it difficult to work as members of a team with other kinds of practitioners (Shuval, Mizrachi, & Smetannikov, 2002). Stakeholders emphasized the obstacles involved in trying to achieve any form of integrated care:

> We have enough difficulties integrating the healthcare providers that are part of the traditional Western teams, nurse practitioners working with family doctors, nurses working comfortably with midwives and social workers, physiotherapists working with occupational therapists. There are turf wars all the time. We have some real struggles in developing interdisciplinary teams (HP10).

One leader thought it would be exceedingly difficult to integrate CAM practitioners into the system when "We can't get our act together even now, with those that are already regulated" (HP2). One stakeholder pointed out that professional education programs make it difficult for healthcare providers from different disciplines to develop a team approach with CAM practitioners:

> We would like to see true interdisciplinary teamwork but we are not trained to work that way. We can look back at the way the educational processes drive wedges between the disciplines and make it very hard for people to change the ways that are comfortable for them (HP9).

Another mentioned that teamwork might be possible but only after research has shown that CAM modalities are safe and effective. This leader emphasized, once again, the need for scientific evidence: "I think that anything that is a legitimate, valid, evidence-based approach that is beneficial to the healthcare of the population ultimately should be delivered as part of an integrated strategy" (HP1). These responses indicate that there are a lot of hurdles to overcome before collaborative teamwork with CAM practitioners can be developed. These stakeholders would have to give up their position as professional monopolizers in order to work in a more egalitarian manner.

Referring

If some form of integration was happening, physicians would regularly refer patients to CAM practitioners. According to our respondents, this is not yet the case. The main reason given was, once again, the lack of reliable evidence for CAM therapies:

> We see direct referral as placing them (physicians) in a medical legal state. They have great confidence that when they refer to a (medical) specialist, they are legally covered in that process. A direct referral to a CAM therapist, they would find difficult from a medical legal perspective. It will be a long time that the evidence is really solid that would allow them to feel comfortable in making a referral (HP10).

Another leader said:

> I would think that if they had an evidence-based outcome that would be complementary to what I do, then sure, I would refer to them—We now know that dentists provide a very valuable focused component of healthcare. I have no hesitation referring to dentists. If that demonstration could be produced for any of the alternative providers, then I suspect that the same kind of relationship could evolve (HP5).

In spite of ongoing concerns about liability and responsibility, referrals from physicians to CAM practitioners are gradually increasing, at least in the UK and the USA (Kessler et al., 2001; Saks, 2002; Thomas, Carr, Westlake, & Williams, 1991). They are not likely to become common practice, however, until the medical profession is convinced that the level of evidence for efficacy and safety is acceptable. The authority to establish what constitutes satisfactory evidence for referral leaves this issue firmly in the hands of medical stakeholders.

Nursing leaders were more open to the possibility of referring to CAM therapists. One predicted that regulation would expand the options that nurses can suggest to their patients, by assuring them of the efficacy and safety of CAM practices:

> It (regulation) may change how nurses are able to consider these other groups for support. Nurses may see a broader base of practitioners to refer to. Traditionally nurses are warned not to refer to

someone who is not regulated. That is the biggest obstacle; nurses are very cautious and very aware of safety (HP6).

It seems that the prospect of integrating CAM into the formal healthcare system can take on different forms, with co-optation and co-operation both playing a part.

While the cautions that these stakeholders express about integrated care are rooted in their concerns for patients, they also serve to constrict the possibilities for integrating CAM into the formal system.

Strategy three—opposing government funding for CAM

At a time when healthcare costs are mounting and governments are increasingly concerned about budgets and allocation of resources, these stakeholders regarded the issue of government funding for healthcare as highly significant. They complained that the government does not currently fund the existing healthcare system adequately. Their fear that if the CAM leaders continue to professionalize, scarce resources will be diverted from conventional medical services in the future:

> We need to look at the dollars that are being spent on healthcare and the dollars that are going to complementary and alternative treatments. A very significant and growing percentage of the dollars that are available are going toward these modalities. We have to use our dollars in the most cost effective way—There is a limit to the resources that can support all of this and therefore those who depend on their profession for their livelihoods feel threatened. If there were a system that supported all of these things appropriately, there would be more support from the medical profession (HP1).

The implication is that government funds should be directed toward conventional medical services rather than being 'wasted' on other forms of healthcare. Once again, these leaders emphasized the requirement that there be credible evidence that CAM therapies work in ways that meet the criteria established by the medical profession. They insisted that the government should give no official support to CAM groups until research has demonstrated that their services are efficacious, safe and also cost-effective. These demands for evidence point to the need for systematic research on CAM.

Government funding for research

Most of the stakeholders, while calling for credible evidence, did not favour government funding for CAM research that could provide the needed evidence. They regarded such a role for government as premature and inappropriate. One of the leaders put it this way:

> Do we fund them to see if they are effective or should they demonstrate their effectiveness and then get government funding? I am not sure there is enough money in the system to fund every interest group who wants to demonstrate their validity. The straight answer is that I don't think we can afford government funds for their research'' (HP5).[1]

The contradiction between their demands for more evidence, and their reluctance to see government funds directed toward CAM research did not seem to trouble these stakeholders. For the CAM practitioners, however, this represents a 'catch 22' situation in which they are disadvantaged in applying for research funding on the basis that they have no research evidence to bolster their requests for support. Yet, they have little support for conducting the required research.

Government funding for education

This same reluctance to divert government funds toward CAM practitioners was expressed with regard to education:

> They should be funded by the students who get the education—Medical care is subsidized and accepted by society. It is a societal decision; the public has said that they want more doctors. I have no idea what the public is saying about these groups (HP5).

A nursing leader argued that there is not enough funding available for educating the established health professions and therefore it made no sense to contemplate funding CAM students:

> In terms of education, we need assistance. Our seats have been limited dramatically across the country. There is a nursing shortage and it will be devastating if we do not train enough students (HP6).

As in the case of research, these stakeholders are claiming that standards of CAM practice need to be improved, but most of them are averse to government support for students at CAM educational institutions.[2]

[1] While the federal agency, Canadian Institutes for Health Research (CIHR) is now the major funding body for healthcare research, its major direction has been in the areas of clinical and biological research. Only recently have they begun to recognize the need for research on CAM.

[2] In the province of Ontario, medical students qualify for government support for education. Students at the various CAM educational institutions do not, however, receive support from government.

Government funding for universal health insurance

The stakeholders all agreed that CAM groups should not be covered by universal healthcare insurance. One leader told us:

> The physician group feels a high level of ownership over the OHIP (Ontario Health Insurance Program) pools and there would be some real difficulty in negotiating with the ministry of health and the medical association over releasing those dollars (HP10).

Another said:

> There will be a reserved approach from medicine to adding new things to the envelope that has limited dollars. I also think that whatever is added does have to prove itself. These other modalities are going to have to prove themselves like we had to do (HP1).

These stakeholders were worried about the health system being under-funded:

> The big challenge in this country is that we cannot afford the cost of healthcare. If we continue to think of it as an open-ended system we are in trouble. Where do you draw the line (HP4)?

As a consequence, they were opposed to opening the door to government-funded healthcare insurance for any new groups. Like the other leaders, the nursing stakeholders affirmed that unless the CAM groups could produce solid evidence of efficacy and safety, the government could not justify putting money into them. However, their view of what constitutes adequate and appropriate evidence was not always the same as the view expressed by the other stakeholders:

> I think there is a turf issue among many practitioners. There is a bias to those things that can't be tested through randomized clinical trials. There is a reticence to different ways of accepting efficacy on the part of healthcare providers already in the field, particularly those that have more to lose like physicians (HP2).

In spite of this more open view, the nursing leaders agreed that CAM groups should demonstrate that their therapies are effective before any government support is given: "New groups should be set up {with OHIP} only after careful study and determination of what their contribution is" (HP6). These stakeholders were unanimous in their view that the inadequacy of government funding for healthcare was a reason to keep CAM groups out of the official insurance system. Here we have a clear example of how countervailing powers structure a situation so that the established healthcare professions (the dominant structural interests) exert influence on government (the corporate rationalizers) to deny public funds to the repressed groups.

Scholars who use a stakeholder analysis approach warn that a critical stance is required in interpreting the responses of the actors involved (Brugha & Varvasovszky, 2000). In the next section, we will endeavour to assess the significance of the opinions expressed by these leading health professionals.

Discussion

The stakeholders in this study were unwilling to say that CAM groups could not or should not become professionalized. But the requirements they spelled out in order for this process to be completed were exacting, rigorous and comprehensive. Their responses implied that since medicine had previously been required to satisfy the highest standards, newcomers would now have to 'jump through the same hoops'. The difficulty here is in deciding who will make the judgment that CAM standards are sufficiently high to warrant professional legitimacy. If the decisions are made by, or heavily influenced by, the established professions, then the same people are both competitors and judges. They have the resources to powerfully advance their own interests. This can create significant areas of contention. For example, how much, and what areas of biomedical education would satisfy these stakeholders that CAM practitioners are sufficiently knowledgeable to deliver safe and effective healthcare?

In particular, who is to decide what kinds of evidence will be credible when it comes to issues of efficacy and safety? And how much is enough? Exponents of the biomedical view argue that any explanatory systems that fall short of what biomedicine defines as evidence can not be valid and are only pseudo sciences (Barrett & Jarvis, 1993; Beyerstein, 1997). For the medical community, controlled trials remain the sole arbiter of a therapy's efficacy and safety (Ernst, 2000). This is in spite of the fact that many medical interventions have not been subjected to randomized clinical trials (Leape, 1994; Sanders, 2003). For example, in the field of psychiatry, few of the cognitive therapies employed have ever been tested by controlled trials (Pelletier, 2003). It is still unclear how these interventions work and if they really make a difference beyond the placebo effect.

Yet, the medical profession has gained social authority as the arbiter of truth in healthcare. The fact that the medical approach to healing and the CAM approach are operating from different paradigms, creates serious difficulties when it comes to medical assessments of the evidence of efficacy and safety for CAM practices. While medicine is rooted in biomedical science, CAM healing practices are founded on other forms of evidence, some of which have extensive formal and substantive

theoretical structures and practice traditions (Thorne, Best, Balon, Kelner, & Rickhi, 2002). Complementary and alternative healing practices emphasize the uniqueness of each individual, integration of body, mind and spirit, the flow of energy as a source of healing, and disease as having dimensions beyond the purely biological (Berliner & Salmon, 1979; Kelner & Wellman, 2000; Oberbaum, Vithoulkas, & Haselen, 2003; Bell, Koithan, Gorman, & Baldwin, 2003). The two models point to different ways of knowing and understanding reality and judging knowledge (Quah, 2003). Currently, the medical profession, as the dominant structural interest, is in the prime position to impose its version of evidence on others (Coburn et al., 1999). This requirement for "scientific" evidence creates a major barrier for CAM groups wishing to gain professional status.

The leaders of the allied health professions were in general agreement with these views, with the exception of some of the nursing leaders. They expressed some understanding of the difficulties that CAM has in meeting the standards of evidence posed by biomedicine and recognized that there are different approaches to demonstrating efficacy and safety. The nursing leaders also suggested that CAM practices would be held to higher standards than some medical therapies such as aspirin have been in the past. The ties that bind the allied health professions to medicine create a uniformity of view among the professional monopolizers. The nurses, however, are more independent of medicine and thus can be more flexible in their views and alliances.

It is important to recognize that times have changed in regard to standards of evidence and that these changes are not particularly related to CAM. In recent years there has been a widespread move to evidence-based medicine and development of clinical practice guidelines (Sackett, 1998). The era of unfettered, individualized decision-making about treatment is fast disappearing for all forms of healthcare. The established healthcare professions are able to take advantage of these new developments to maintain the boundaries around their own professional authority.

Regarding the integration of conventional medicine and CAM, the most striking finding was that the leaders of the established health professions had differing perceptions of what integration means. Most conceived of an integrated system as one in which physicians themselves employ CAM therapies such as homeopathy and acupuncture within their medical practice. This has been referred to as 'limited incorporation' by Saks (2002), who identifies it as a strategic option adopted by the leaders of the medical profession in the United Kingdom to control competition from CAM practitioners. In Ontario, the medical profession has actively lobbied the government to include acupuncture as part of the practice of medicine and to separate it from traditional Chinese medicine and its underlying philosophy. Until recently, a physician who used complementary or alternative therapies in his or her practice could be subject to disciplinary proceedings. In December, 2000, a bill was passed in the legislature which permits physicians to incorporate CAM practices into their medical treatments (Bill 2, an Act to amend the 1991 Medicine Act). It provides that a physician shall not be found guilty of professional misconduct solely because of CAM use. The bill opened the door to limited incorporation by the medical profession in Ontario (Manzer, 2001). This practice runs the risk, however, of altering the very nature of the therapies into a form that is much more compatible with conventional medicine and much less like the original healing process (Bourgeault, 2000; Gilmour et al., 2002; Kelner et al., 2002).

The leaders of the nursing profession also showed considerable interest in incorporating CAM practices into nursing. Since their scope of practice is broad, they see it as an opportunity to strengthen their role in healthcare by taking on some of the treatments that are currently being delivered by CAM practitioners. All the leaders of the established health professions were comfortable with this version of integration; one that transfers selected CAM therapies to their jurisdiction.

Another version of an integrated system expounded by many of the leaders was one in which physicians act as the sole gatekeepers to healthcare. They believed that integrated care should not proceed without the approval of a physician to 'open the gate' to non-medical kinds of treatments. This maintains the authority and control of this stakeholder group over healthcare and keeps the aspiring groups at bay.

A third conception of integration is one in which healthcare is delivered by multidisciplinary teams that include CAM practitioners as equal partners. The leaders of the established healthcare professions saw this as a distant possibility that would be extremely difficult to achieve. They did not favour this kind of integrated care and raised doubts about the competence of the CAM providers as well as about the feasibility of working together. They were unwilling to entertain the notion of working alongside CAM practitioners as equal colleagues on an integrated team.

Concerning what role the provincial government (the corporate rationalizers) should play in restructuring the place of CAM practitioners in the healthcare system, these stakeholders were unequivocal in their views. They all worried that the government might divert resources away from their professions in order to assist the CAM groups to upgrade their educational and research programs. They were even more negative about the possibility of CAM practitioners being included in the provincial health insurance scheme. The vast majority of the leaders saw government funding as a zero sum game, in which they would lose out if CAM groups won any monetary concessions. Only a very few leaders suggested

that CAM therapies might provide some cost savings to the system, which would permit a reshuffling of the available resources. None of them suggested spending money to research the cost-effectiveness of CAM. They were more sympathetic to the role of government as a regulator of CAM practices, but many were concerned that statutory self-regulation might confer a respectability on CAM practitioners which they have not earned through scientific proof. In general, the argument that there are insufficient funds to assist CAM groups in professionalizing, can be viewed as one more tactic to keep these groups outside of the established system.

The argument that only physicians have the appropriate training to properly diagnose a health problem is another protective mechanism. The stakeholders argue that to protect the patient, a medical doctor must ascertain whether a CAM therapy could be helpful, and moreover, which kind of therapy is indicated. This argument ignores the fact that most patients of CAM practitioners also see their physicians at least once a year (Kelner & Wellman, 1997). It also assumes that physicians have sufficient knowledge of CAM practices and practitioners to know when and to whom to refer. Meanwhile, the educational requirements for a number of groups of CAM practitioners are increasing (Kelner et al., 2002), and as a consequence, the ability of these healthcare providers to accurately diagnose is improving. The claim that it is necessary for physicians to be 'gatekeepers' in order to protect patients, is becoming less convincing.

When it comes to influencing health policy, the established health professions strive to convince government to restrict funding for research and education and health insurance to themselves. Meanwhile, the CAM groups have been unable to access these resources. The established professions exert this influence through strong lobby groups and well-organized, experienced professional associations. By contrast, few of the CAM groups have cohesive organizations and therefore find it difficult to make their case to government in a forceful and convincing manner. Furthermore, there is little communication and some competition between the various CAM groups (Boon et al., 2003). As Alford (1975) and Light (2000) point out, repressed groups require enormous organizational energies and resources in order to overcome the disadvantages of their situation. The CAM groups are seriously inhibited in their ability to counteract the impact of the established professions on government decisions about health policy.

If we see all this jockeying for position within Abbott's (1988) framework of the healthcare system, it becomes apparent that there are significant niches still open for the CAM groups to occupy. The increase in longevity with its corresponding growth in chronic illness, the growing emphasis on prevention and the restructuring of primary care all create what appear to be new opportunities for CAM. The interests of the established healthcare professions, when faced with this challenge, dictate that they work to maintain their professional monopoly by constraining change in the system. This stakeholder group wants to fill the vacancies with its own members by co-optation of CAM, thus expanding it's own roles. At the same time, these dominant structural interests are working to erect barriers that will inhibit the ability of CAM to move forward. The interests of the state in this process are divided. Government is responsible for the safety of consumers of healthcare, the curtailing of costs, and responding to the demands of the community for CAM therapies as well as the claims of the established healthcare professions. These countervailing powers are involved in a dynamic process in which their interests both collide and converge. At this moment in history, the established healthcare professions are in a position to effectively constrain the ability of the CAM groups to professionalize. How the future unfolds will depend on the relative strength of the various players in the system, and the resources they can summon to advance their own interests.

Conclusion

The systems framework used here to analyze the professional project of selected CAM groups has permitted us to specify the interests of the various groups involved and the strategies they are using to promote their particular interests. It is clear that within the formal system, there are competing forces with unequal power and resources. If the CAM groups continue to seek a legitimate place for themselves in the healthcare system, this research make it clear that they will face active resistance from the established healthcare professions and a series of systematic demands from government. If, however, the groups are prepared to forego professional status, they would not be compelled to follow the rules of the game. If they chose to remain outside the formal system and operate independently as market-driven practitioners, these countervailing powers would have much less influence on their fate. However, in a society that places a high value on credentials and certified expertise, this seems an unlikely scenario for the future.

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