Self-regulation in a small professional group is an important step toward professionalization: the Chiropractic Association in Singapore

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Abstract

Objective: The chiropractic profession is immersed in the process of professionalization with particular consideration of self-regulation as an avenue toward state recognition in Singapore. The purpose of this article is to discuss the emergence of chiropractic as a profession in Singapore and the Chiropractic Association (Singapore).

Discussion: The concept of professionalization is varied and context based, and the institutionalization of formal knowledge plays an important role in the socialization of how a profession forms a unifying identity. The difference in institutional socialization of the professions plays a role in the way a profession is perceived in the hierarchy of societal power. Continuing professional development is an essential part of professionalism and is best done within the realm of self-regulation and autonomous control of the profession itself.

Conclusion: The social process of professionalization can be a process of internal conflict and external battles almost from the profession's inception with university training only entering late in its development, rather than being a linear development. A sequential progress ensued as with other professions, with the seeking of legal protection and a code of ethics as the final areas reached toward becoming an acknowledged member of the health care system.

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Introduction

The chiropractic profession continues to change and grow in a dynamic health care environment. There are both internal and external pressures toward greater formalization and structure of the chiropractic profession in countries where it is establishing itself such as Singapore. The questions that arise include the

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following: “How does a relatively small professional organization, such as a chiropractic organization, self-regulate in a changing health care environment?” “How did the professionalization process develop in the chiropractic profession?” “What professional practices are evident in the chiropractic profession?”

This article discusses the emergence of chiropractic as a profession, specifically the Chiropractic Association (Singapore) (TCAS), in the cultural context in which it is immersed with particular consideration of self-regulation as an avenue toward state recognition.

Cultural context

Singapore attained independence in 1965 after a long period under British rule. Although there were several professional associations in Singapore before independence, new structural organizations within professions and new legislation for the main professions over the first few years that followed built on a dual principle: some control of the activities of professionals through state intervention and a facilitation through the provision of legislative means to expedite the professional’s contribution to the economic development of the nation.¹ Quah¹ acknowledges that some aspects of Singapore’s situation may have been quite different from that of other countries because of its unique combination of small size; a heterogeneous population in religion, ethnicity, and language; and a rather distinct political system and pattern of economic development. These differences notwithstanding, the structure and nature of the four professions in Singapore (medicine, law, architecture, and engineering) “resembles that of their counterparts in developed countries.”

Relative to complementary and alternative medicine there was no regulation in Singapore during colonial rule, and the first 30 years of the republic were characterized “by the government’s *laissez-faire* approach to traditional Chinese medicine,”² suggesting that this was based on the belief that the practice of traditional Chinese medicine was part of the Chinese culture with appeal to the public. However, this *laissez-faire* attitude of the Singapore government changed into active scrutiny and regulation in the mid-1990s, suggesting a policy shift toward upgrading the quality of recruitment and training and insisting on self-regulation. The justification of this shift happened with the opening up of China and the increased interest in alternative medicine the world over and recommenda-

tions by the committee, appointed by the Ministry of Health in 1994 as result of visits to Taiwan, Japan, South Korea, and Hong Kong, to share expertise, experience, and qualified personnel for research and development of traditional Chinese medicine.³⁻⁵

The government has used intervention and encouragement of self-regulation in the case of the Chinese medicine practitioners as well as the chiropractors. The concepts of having a gatekeeper in the form of a board with representatives including public service officers, academic staff, and practitioners is similar for the traditional Chinese practitioners as for other professions with the role of maintaining a registry and to regulate professional conduct and ethics, although there may be differences in representation and roles for different professions.^{1,2}

Self-regulation

One way of considering self-regulation is as a substitute for command and control, another as self-administered command and control.⁶ The term *self-regulation* does not have an accepted definition, and in its simplest it may refer to individuals and organizations to regulate their own conduct. In the context of regulation, it more usually involves an organization or association that develops a system of rules that it oversees and enforces within its membership.

The case in favor of self-regulation rests principally on expertise and efficiency⁶: self-regulatory bodies usually have higher levels of relevant expertise and technical knowledge than is possible with independent regulation and have easy access to those under control, thus acquiring information necessary to formulate and set standards at low cost, and furthermore have low monitoring and enforcement costs as they are able to adapt to changing conditions in a flexible and smooth manner and tend to enjoy the trust of the regulated group. A counterargument to this is that the expertise and knowledge can be “brought in” by bodies independent of the profession or membership. This does not ensure the proximity to the regulated group, however.

A key consideration may be whether the expertise and efficiency gains to be achieved by self-regulation do out-balance any weakness in mandate definition, accountability, and fairness that will remain after appropriate steps have been taken to ward off criticism on these fronts.⁶ Self-regulation can be classified as “enforced” when it is subject to a form of governmental structuring or oversight.

The criticism of self-regulation can be seen both from a legal and from an economic point of view.⁷ “Corporatism” has been mentioned as a problem from a legal perspective whereby power can be acquired by groups that are not politically accountable. The fact that self-regulating agencies have the capacity to make rules that govern activities of an association that may not have democratic legitimacy in relation to its members can lead to abuse. The lack of separation between functions of policy formulation, interpretation of the rules, adjudication, and enforcement further opens up the potential abuse of power. Ogus⁷ also points to the poor record that self-regulating agencies have in enforcing their standards against non-cooperative members.

Self-regulatory bodies have the capacity of dual action in that they may act governmentally while possessing the institutional, and often legal, structures and interests of private bodies. In general, they regulate entry to an association and formulate their own rules and enforce discipline.⁶ According to Ogus,⁷ one problem with the traditional criticism is that they are painted with too broad a brush. In the question of autonomy, he sees “no clear dichotomy in this respect between ‘self-regulation’ and ‘public regulation,’ but rather a spectrum containing different degrees of legislative constraints, outsider participation in relation to rule formulation or enforcement (or both), and external control and accountability.”

The role of professional associations

The role of the professional association is succinctly put by Merton⁸ such that: “the professional association *is* as the professional association *does*. Its manifest and latent social functions, not the structures designed to put these functions into effect, constitute its social excuse for being.”

The association is usually a voluntary one with the voluntary-ness of membership varying from profession to profession depending on the penalties for not belonging. The function of the profession is to protect both the members by working toward legally enforced standards and in helping to motivate practitioners to develop their skills and to extend their knowledge. This function is aimed at the members of the profession and not only at the members of the association, however.

According to Freidson,⁹ the source of legitimacy lies within the profession, but not necessarily within the program of its association. The occupationally generated policies can well be generated by “a distinguished member of the profession, by a commit-

tee of members of the profession who advise the state and its agencies, or by professionally qualified staff in state agencies.” It is not important whether the representative of an association or some other credentialed authority advances it. According to Merton,⁸ another aspect of an association’s function is to be committed to being dissatisfied with the current state of the profession in the sense that it is engaged in pressing for higher standards or personnel, education, research, and practice. The expectation by society in return is authentic information to the public and that standards are raised, in turn improving the social standing of the profession.

In the early stages of the development of the professional associations, the active membership is composed largely of elite practitioners. Their interest is mainly to preserve and solidify their official and public status, in part given by state recognition and support, in part by preventing the decline in status that might occur if practitioners of more humble origins become members. Once over the formative period of forming the institutions of professionalism, when the struggle is to gain official privilege and control of jurisdictions, labor market shelters, and training, the profession enters the established period with all the institutions in place. The profession now becomes less preoccupied to defending its jurisdictions from interlopers than with extending the application of its disciplines.^{9,10} Once privilege is gained, contention occurs between credentialed practitioners within the officially sheltered marketplace. It occurs through internal differentiation that is driven by the expansion of knowledge, skills and their applications, the invention of new skills, and the variety of practices that develop. Established professions come to be composed of a number of highly differentiated subcommunities loosely held together by a common occupational title, and they may be in conflict with each other, sometimes holding contradictory disciplinary and policy positions. But because they are all positions within the profession, they are legitimate even when they contradict each other.⁹

Wondering whether the activism of associations in fact is a necessary condition for establishing professionalism or appears as a key element of a natural progression of this process, Freidson⁹ puts forward that private, self-organizing associations only seem essential when the state is reactive. In reactive states, he maintains, because there is minimal intervention in officially recognized private interest groups other than to ratify and enforce policies that are created by favored occupations, the associations

are left free to control their own affairs. Although this *laissez-faire* philosophy may be characteristic, the agencies that serve the chosen occupation usually are small. On the other hand, if the state follows what can be characterized as closer to an activist mode of formulating and implementing policies, there might be suspicion of self-organized civil groups that are seen to threaten the ideology of the state. The system in Singapore may be said to resemble the latter type of state rather than the former, which according to this view would mean that the association has less influence than the profession in a broader sense, or even influential members of the profession. If there are several representatives of a profession, the state can choose one rather than another to represent the interests of “the” profession, making it even more imperative from the viewpoint of the profession as a whole that it unites in its views to speak with one voice. Similarly, compulsory membership of a chosen association is also within the power of the state.

The role of the association is to justify the scope, and often the expanding scope, of the jurisdiction of the profession and to be a safeguard against rival claims of neighboring professions.⁸ The strain that is often seen with neighboring professions derives in part from the pressure toward expansion, deriving in part from advancement of professional knowledge, and underscores the importance of maintaining effective liaison between professions. The professional association also plays an important role in mediating the many-sided relations of the profession to the government. The association must represent as large a portion of the members of the profession as possible in order to be able to speak on behalf of the profession, striving for what Merton⁸ calls “completeness” by including all those eligible for membership.

Regulation in health care exemplified by the United Kingdom

The activity of regulation in Britain has a long history as seen in the example of the 1512 Medical Act. Another early legislative intervention of the medical profession, the Medical Act 1858, was enacted against a backdrop of the growing commercial success of the irregular practitioners, leading to what Stone and Matthews¹¹ refer to as the “only option left” to elite medicine to professionalize. The way that medical regulation has been enacted has

been largely at the instigation of the party seeking to be regulated. This has been and still is a reflection of the 2 facets of regulation: regulation as a source of restriction and regulation as a means of economic opportunity.

It has been the public choice approach of regulation that has dominated the development of regulation of the medical profession. This has been translated to mean¹¹ that regulation was promoted by doctors that had more to do with “professional closure and self-protection than with protection of consumer interests.” The enforcement of training standards that was a consequence of such legislation undoubtedly also benefited the public indirectly. These implications of this bias relate to accountability and consumer protection as the primary aims for self-regulation.

One great advantage of self-imposed professional self-regulation is attained if those doing the regulating are in touch with the general body of professionals because of the greater proximity and knowledge of its membership. This was clearly seen in the current study where every member was involved with the self-regulation document.¹² However, in many cases there is an inevitable gap between leaders and the led, asserts Stacey,¹³ because there is something different about having “one of us” giving out orders rather than a “rank outsider” who “just doesn’t understand.” Membership of a self-regulating profession is likely to increase the sense of worth of its members and, given appropriate working conditions, this is likely to enhance the standard of their work.

The criteria that a well-regulated medical profession may be said to have are set up by Stacey¹³ in the following. They equally apply to chiropractors, and all points were included in the self-regulation document of TCAS:

1. Only appropriately qualified doctors are admitted to practice;
2. Those in practice are competent;
3. That they work conscientiously;
4. That they do not exploit their patients economically, socially, or sexually;
5. They do not exploit their colleagues or subordinates;
6. That patients or their representatives have ready access to the regulatory body in case of alleged failure of practitioners in any of these respects;
7. That patients or their representatives should receive equitable and adequate compensation for any damaging resulting from medical accidents or misdemeanor; and

8. That practitioners are afforded appropriate protection against wrongful actions of patients, employers, colleagues, or others.

The theme of consumer protection has been consistently invoked to justify the political positions of both orthodox and unorthodox medicine originally seen with the first Medical Act in 1512 with the specific aim of protecting the public from charlatans and unskilled practitioners. “Beyond the rather obvious point that the language of consumer protection has often been little more than a convenient veneer to mask more self-interest goals”¹¹ stands the divergent interpretation by the 2 groups of what constitutes the public interest in health matters. In this sense, legislation is a response to the competing demands of interest groups—and that regulation serves mainly to confer rent (supra-competitive profits) on the regulated actors.⁷

The dominant model used by governments until recently was to regulate health care providers by way of either a licensure or a certification system. A licensure regime means that only licensed members of a profession can provide services that fall within its the scope of practice. The monopoly thus granted for the members of the professions whose scope of practice is particularly broad, for example medicine, therefore provides a wider monopoly of services.¹⁴ The certification regime allows only qualified practitioners to use a designated title. The “right to title” indicates that this practitioner fulfills the required educational and training standards and is subject to a particular code of ethics.¹⁴ Importantly for chiropractors in relation to the use of manipulation, it does not mean that only those practitioners can perform a particular service but it is meant to act as a form of quality assurance.

In general, self-governing professions have an exclusive scope of practice and have a right to title and perform 4 critically important regulatory functions. According to Casey and Picherak¹⁵ these are to:

- Act as “gatekeepers” to the profession by typically establishing and enforcing entrance standards for the profession.
- They establish standards of practice for the profession providing guidance to members of the profession on the performance of their duties.
- They establish continuing education of continuing competence requirements members must follow to maintain their competence throughout their careers.

- They administer a professional disciplinary process designed to protect the public from incompetent or unethical professionals.

Regulation in chiropractic worldwide

Government recognition of the practice of chiropractic is widespread.¹⁶ This official recognition takes three basic forms:

1. *Legislation*, for example in the United States and Canada, all the Scandinavian countries, the United Kingdom, Australia, New Zealand, Hong Kong, Philippines, South Africa, and several other countries in all regions.
2. *Recognition under general law* without the existence of specific chiropractic legislation, included in Singapore, Malaysia, Japan, most countries in the Latin American region, most of the Eastern European countries and the Russian Federation, and the smaller countries in the North American and the Eastern Mediterranean regions.
3. A few countries have *de facto acceptance*, where the practice of chiropractic is “technically in breach of medical practice law, but is acknowledged and not obstructed by national health authorities.”¹⁶ Some of these countries are notably Italy, France, Spain, and South Korea.

The practice of chiropractic has been regulated in the United States and Canada since the 1920s, in Australia since the late 1940s, in New Zealand and South Africa since the 1960s, and elsewhere more recently.¹⁷ With the medical profession being more willing to recognize the limits of modern medicine and the potential contribution of nonconventional therapies,⁹ and with chiropractic as one of the “discrete clinical disciplines” identified by the British Medical Association (BMA) to have “potential for greatest use alongside orthodox medical care” with a recommendation to legislate in order to regulate these disciplines,¹⁷ the road was paved for greater integration of complementary medicine within the National Health Service in Britain. After the BMA’s recommendation, the Chiropractor’s Act was enacted in the United Kingdom in 1994, establishing the General Chiropractic Council, where regulation was provided for the chiropractic profession. The registration of chiropractors was provided in the same act and provisions were made as to their professional education and conduct and, importantly,

in connection with the development and promotion of the profession (Chiropractors Act 1994).

The general functions of the corporate council are reflected in the regulatory bodies as well as promoting cooperation between the regulatory bodies. For the General Chiropractic Council (GCC) the main four duties are

1. To protect the public;
2. To set the standards of chiropractic conduct, practice, and education;
3. To develop the profession, using a model of continuous improvement in practice;
4. To promote the contribution that chiropractic makes to the health of the nation.

The Code of Practice lays down the standard of personal and professional conduct required by chiropractors and provides advice in relation to the practice of chiropractic. The Standard of Proficiency sets out standards for the competent and safe practice of chiropractic for chiropractic as “an independent primary healthcare profession.”¹⁸ The standards set out here relate to patient management, practice management, and effective communication¹⁹: “The law does not define the scope of practice for any healthcare profession. Nor is it the purpose of the *Standard of Proficiency* to define the scope of chiropractic.”¹⁸

The “public interest” and “public choice” models of regulation have within them the tension discussed that lie between the 2 principally conflicting aspects of regulation: regulation in a restrictive sense and regulation as an instrument of economic opportunity.⁹ Much of the impetus for regulation comes from within the chiropractic profession itself partly due to an increasing incentive to use the title “chiropractor” by “lay healers” and others without formal training¹⁷ as the discipline has gained more acceptance. But there has also been an apparent shift in attitude of governments toward regulation with increased patient usage and interest in complementary medicine and self-care techniques.⁹ Chiropractic education and research efforts since the mid-1970s have led to respected advances for the profession²⁰ with scientific corroboration supporting methods of management for back pain.

The most common model of regulation in chiropractic regulation is, according to Chapman-Smith,¹⁷ that of self-regulation under a chiropractic board or council. The question of the relationship between gaining self-regulation legislation and actually gaining

full professional status is attempted to be answered by Gilmour et al.¹⁴ Full legitimacy is not only fulfilling the criteria of a profession, but also receiving the credit of society. The chiropractic profession has thus succeeded in gaining self-regulated status in Canada but is still facing opposition from the medical/scientific community and has yet to achieve full professional legitimacy there.¹⁴

There are 3 models of regulation in chiropractic legislation: self-regulation, regulation under an inter-disciplinary board, and, in instances where there are very few chiropractors in the jurisdiction, regulation by another regulatory organization or individual.¹⁷

A chiropractic council or board generally has a majority of representatives being practicing chiropractors, but some lay representation is appointed by the government to represent the public interest. Under the second model of regulation, a modified self-regulation under an interdisciplinary board, there are a variety of arrangements, reflecting local conditions. Up until recently, osteopathy and chiropractic were under a joint regulatory board in the state of Victoria in Australia,²¹ and in South Africa the Chiropractors, Homeopaths and Allied Health Service Professions Council had 5 chiropractors appointed out of between 12 and 15 representatives with the other members being representatives of the other professions and 1 officer from the Department of Health and Welfare.¹⁷ The third type of regulation has been used in jurisdictions with few chiropractors to ensure that only duly trained persons may practice as chiropractors and to regulate their practice. Examples are Cyprus, where only 5 chiropractors practiced when the Chiropractor's Registration law was passed in 1991. Regulation is under a registrar, an officer of the Ministry of Health, there being no chiropractic council.

The international health care arena is not a uniform one but is shaped, planned, and regulated according to the political and socioeconomic dynamics governing societies.²²⁻²⁴ The way the chiropractic profession is regulated is thus influenced by the national social structures, health care systems, and the role of medicine in the various countries.²⁵⁻²⁷ However, governments are also conscious of popular support of chiropractic care, and medical objections to giving legitimacy to the profession through legislation are not always heeded, adding the consumer to the power relationship.²⁷

The Singapore legal system has roots in the English common law; it therefore seems most pertinent to examine regulation in this context and to draw examples from elsewhere to illustrate differences. In particular, a glance at Hong Kong will be made to

observe the way an Asian country has dealt with legislation of chiropractic.

Legislation compared

Common for the legislation in North America, Australia, and New Zealand as well as Europe is the graduation from an accredited educational program as the prerequisite for regulation or licensure.¹⁷ The legal scope of practice is not the same in every country. It varies from, for instance, being present in all states but differing from state to state in the United States to, for instance, the status in those countries that have adopted an approach that has no definition in the legislation because the description of scope of practice is a matter best left to the regulatory body, as for example Australian state legislation, in Hong Kong, Mexico, New Zealand, South Africa, the United Kingdom, and other countries (Table 1).

Whereas some countries have adopted a broad definition, a narrow definition such as that of the Danish includes “the diagnosis, prevention and chiro-

practic treatment of biomechanical functional disorders of the spine, the pelvis and the extremities.”¹⁶ The Danish law makes specific reference to the use of x-rays in chiropractic practice, whereas another convenient method of making provision for imaging and other diagnostic methods is to establish appropriate broad powers of regulation in the act, then use regulations. This approach is used for example in Hong Kong, New Zealand, and the United Kingdom. The Hong Kong Chiropractors Registration Ordinance authorizes regulations by the Governor in Council for “anything that is to be or may be prescribed.”¹⁶

Issues within the maturing chiropractic profession

The maturing of the chiropractic profession, supported by satisfied patients and sympathetic politicians, has expanded the access of chiropractors to patients and to third-party reimbursement even though chiropractic’s various legislative and legal efforts have not always been successful.²⁸ However, “their long effort to gain access to reimbursement was waged largely during the fee-for-service era, during which chiropractors were paid principally out-of-pocket, but their victory carries with it the constraints of managed care and the expectations of patients that others will pay for the services rendered.”²⁸ The uncertainty of the appropriate amount of visits and the not yet well established efficacy of treatment, especially beyond low back pain²⁹ and neck pain,³⁰ has led employers to become less cooperative. These circumstances could lead to diminishing reimbursement and together with the expected rise in number of chiropractors²⁸ could have a profound effect on future income levels.

Still struggling to bridge the gap between the alternative and mainstream health care, chiropractors may have some difficulty in becoming integrated into the mainstream, but their “role in alternative medicine is unequivocal.”²⁸ In figures, almost one third, 192 million, of the 629 million visits to complementary and alternative medicine (CAM) providers in the United States in 1997 were to chiropractors,³¹ and use of medicines that are not part of conventional pharmaceuticals and use of alternative therapies is increasing.³² The use of CAM in Australia is likewise increasing with acupuncture now an established complementary medical practice.³³ CAM is popular in many countries with the prevalence of use varying

Table 1 Overview of some of the issues reflected in current legislation of chiropractic worldwide

Issue	Reflected in the Legislation
Protection of title	Yes
Courtesy doctor title	North America, Hong Kong; unclear in Australia. Those with DC degree.
Right to diagnose and use x-ray imaging	Yes, by way of broad powers of regulation in general. Danish law more specifically includes use of x-rays by chiropractor.
Separate discipline	In all countries, with only 1 or 2 exceptions
Protection of the right to perform spinal manipulation	Generally not. In some instances restricted to medical doctors, osteopaths, physiotherapists, and chiropractors.
Right to practice as primary contact (ie, without referral from medical practitioner)	Yes
Regulation authority	Self-regulation under chiropractic board or council most common
Right to equal representation on regulatory councils	Yes
Right to define education level of registered chiropractors	Yes, by the council/board
Insurance coverage	Extensive

from around 60% in Germany and Canada, 50% in Australia and France, and 40% in the United States and Switzerland with Sweden and the United Kingdom hovering around the 20% mark.³⁴ The variation in numbers does not reveal who is practicing; for example, in Germany and France, contrary to the United Kingdom, medically trained doctors mostly practice it.

Meeker³⁵ points out that funding from the National Center for Complementary and Alternative Medicine now includes chiropractic research putting chiropractic firmly in the alternative camp. Instead of doing what other professions at the “cusp of expanding knowledge”²⁸ have done, namely to subordinate routine tasks to others as their role grew, as pointed out by Abbott,³⁶ chiropractors have expanded into sale of, for example, nutritional supplements, orthotic supports, and offering other therapies, such as acupuncture, massage, and dispensing of herbal medicine and homeopathic products, with license to do so in many states in the United States. However, the barriers of entry into alternative medicine are low, and herbals and botanicals are widely available with many licensed and unlicensed healers offering similar services and self-help literature being offered in books and on the Internet. Certified acupuncturists are on the rise, and the number of massage therapists is growing. Furthermore, many medical doctors have become providers of CAM in Canada,³⁷ and in the United Kingdom, doctors who practice CAM are predominately general practitioners (GPs) similar to doctors who practice CAM Australia.³⁸

The reason for patients seeking CAM treatment is not necessarily dissatisfaction with conventional medicine,³⁹ but an increasing knowledge about CAM and seeking a more egalitarian process within the consultation together with a sense of appropriateness of this model of approach is more congruent with their own values, beliefs, and philosophical orientations toward health and life.³² In other words, patients are not seeking efficacy, but meaning and context. The touch, empathy, and positive expectations experienced by patients may have relevance, suggest Cooper and McKee,²⁸ in the consistent expression of satisfaction with chiropractic care than with other forms of treatment,⁴⁰⁻⁴⁴ or with “the chiropractic encounter.”²⁸ Part of the strength of chiropractic may lie in the domain of the art of healing and how the chiropractic profession negotiates the patient-physician relationship. The connection and compassion embodied in the gift of the hands is ultimately what chiropractic conveys to patients.²⁹

Although many practices within complementary and alternative health care are associated with health promotion, prevention, and population health approach, as pointed out by Achilles,³⁷ conventional medicine too is undergoing a transition and has recently incorporated such practices as “patient-centered care” and “holistic care” into its core values.^{12,37} This raises the question whether medicine’s main omission—the failure of holism—indeed may be what is driving complementary medicine.⁴⁵ With the increased popularity, medicine runs the risk of being isolated from CAM due to lack of enough “scientific” evidence to accept or reject most CAM.⁴⁶ Meanwhile, there has been a response within the medical community to incorporate elements of CAM into comprehensive treatment plans alongside orthodox methods. This approach is in the United States called integrative medicine and in the United Kingdom called integrated medicine. These convergent pathways of medicine and CAM, together with the unsettled definitions of CAM and whether chiropractic should embrace this model,³⁵ are problems that are far from settled. Even if the changes may be seen from the point of “alternative patients”⁴⁷ and not just alternative therapies, the chiropractic profession is held up in CAM circles in the United States as the best model of CAM that can be integrated into mainstream health care.³⁵ Nelson⁴⁸ characterizes the chiropractic profession as being at a crossroads and suggests a clear and coherent message based on 5 principles that could define chiropractic’s role within the health care system:

1. Chiropractic as an integrated and complementary part of the health care system.
2. Portal-of-entry patient access.
3. A scope of practice defined by clinical mastery.
4. Conservative health care, both noninvasive and minimalist.
5. Evidence-based practice guidelines.

The patients have made up their minds to see chiropractors as a mainstream profession specialized in the treatment of musculoskeletal disorders.⁴⁹⁻⁵¹ However, Meeker and Haldeman⁵² agree that chiropractors see themselves at the crossroads of mainstream and alternative medicine and have yet to decide its professional and social identity as a unified group.

Fig 1 lists the issues that now are fulfilled by the chiropractic profession regarding what are considered requirements to have the status of “profession.”

No single definition of professionalization was found in the literature, but several models of approach

On the road to professional recognition chiropractic now fulfils many of the requirements for a profession:

- ✓ Statutory self-regulation in many countries
- ✓ Governing body in those countries that have legislation
- ✓ Corpus of knowledge although much in common with medical science also specialised chiropractic knowledge evidenced through research.
- ✓ University-based education or university-affiliated education
- ✓ Demonstrated efficacy of therapeutic approach
- ✓ Voluntary self-regulation and in many countries statutory self-regulation
- ✓ Research collaboration with universities
- ✓ Postgraduate continuous development in several countries
- ✓ Pursuing policy-level involvement

Fig. 1. Requirement fulfillment toward status of a profession.

were. Wilensky⁵³ suggests a stepwise sequence of development, and although other authors may not agree with his orderly sequential approach, there is a general agreement as to the areas of development that a profession goes through in becoming a profession:

- Full-time activity
- University training
- Professional association
- Redefinition of core tasks
- Internal conflict
- Competition with neighboring professions
- Seeking legal protection
- Code of ethics

Another model regards professionalization as an ongoing social process of simultaneous developments in a nonlinear fashion. A different approach regards the continuum of professions reaching from the least skilled to the well recognized and the in-between

Fig. 2. Timeline of important developments in chiropractic between 1895 and 2005.

“semi-professions” in their attempt to become more formalized and recognized.

The World Federation of Chiropractic

Internationally, the World Federation of Chiropractic (WFC) was formed in 1988, with Singapore as one of its founding members. It represents chiropractic associations from 70 countries. In 1997, it was admitted into official relations with the World Health Organization (WHO) as a nongovernmental organization (NGO).¹⁶ The WHO guidelines on basic training and safety in chiropractic⁵⁴ are further evidence of the changed status of chiropractic.

A timeline depiction in Fig 2 summarizes some of the major developments within the chiropractic profession from 1895 to 2005.

Conclusion

The chiropractic profession has gone through a professionalization process similar to that of other small groups. TCAS is similarly and currently taking important steps in the social process of higher formalization and recognition as a member of the formal health care system.

The models of profession were shown to be different in more than the process itself, however. Important influences in approach were found to have root in the national differences and how this affected the way professional associations create and close the market through accreditation and licensing. The state and its relations with the professional associations and their regulatory efforts were found to be of prime importance in the process of becoming an acknowledged and recognized profession.

Whereas market control was shown to be mainly via the state in continental Europe, this happened via the professional associations in the United States and Great Britain. In Singapore, it was shown that its British colonial roots had some influence on the government's flexible approach to regulation and its willingness to self-regulation within the professions. The approach taken by Singapore was shown to be one of state intervention with cooperation of the professional associations in establishing self-regulation. This approach also corresponds with the approach of hierarchic societies, shown in Fig 1, stressing participatory modes of regulation.

Thus, TCAS has adapted to an already established framework, following the encouragement of the government with an internally driven self-regulation as collegiate control in its efforts toward greater formalization.

The importance of the professional association in the self-regulatory efforts compared well with the full cooperation found in the approach taken by TCAS. The association was shown to have played a pivotal role in this process.

Finally, it was demonstrated that the social process of professionalization within the chiropractic profession included all the areas that other professions have been shown to go through, but as demonstrated in Fig 2, the development did not follow a straight line. On the contrary, it was shown to be a process of internal conflict and external battles almost from the profession's inception and with university training only entering late in its development.¹⁰ The development in Singapore, however, was shown to be similar to the sequential progress with the seeking of legal protection and a code of ethics as the final areas reached toward becoming an acknowledged member of the health care system.

We suggest that continuing professional development is an essential part of professionalism and is best done within the realm of self-regulation and autonomous control of the profession itself. The concept of professionalization is varied and context based and the institutionalization of formal knowledge plays an important role in the socialization of how a profession forms a unifying identity. Further, we suggest that difference in institutional socialization of the professions plays a role in the way a profession is perceived in the hierarchy of societal power.

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