Autonomy and Practice: the Case of Complementary Practitioners in the UK

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*Objectives:* 1. To identify the level of acceptance of the principle of British Medical Association (BMA) participation in the formulation of practice guidelines for complementary medicine amongst currently active non-orthodox practitioners in the UK. 2. To identify the level of support for individual BMA proposals. 3. To identify similarities and differences of attitude to the proposals between practitioners of selected non-orthodox therapies.

*Design:* A postal survey of 1000 practitioners of complementary medicine.


*Study participants:* One thousand currently practising UK complementary therapists from 4 groups — chiropractic, “lay” homeopathy, medical herbalism and reflexology. Systematic sampling (every nth practitioner) was used to select 250 respondents from membership lists of relevant representative bodies. The response rate was 57%.

*Results:* The principle of BMA participation in policy formation was accepted by the vast majority of respondents, although 87.7% stipulated that this should not constitute a major role. Each of the individual BMA proposals received majority support. Acceptance rates varied from 59.7% to 92.9%. Statistically significant differentiation between therapies was recorded on certain proposals.

*Discussion:* The revised stance of the BMA is finding a potentially receptive audience amongst UK complementary practitioners. There is a large amount of common ground between the proposals and what is acceptable to practitioners. However, the situation is complicated by intra-sectoral differentiation. Particular therapy and issue-specific barriers exist to the universal utilization of the kind of measures proposed. © 1997 Elsevier Science Ltd. All rights reserved.

Key words: Complementary medicine, British Medical Association, good practice, intra-sectoral differentiation.

OBJECTIVES

The potential role to be played by complementary medicine within the health care system of the UK has become a matter of considerable debate during recent years. One frequently raised point of contention has been the perceived lack of measures to properly ensure the quality of care given, for example, the lack of proof available to substantiate claims of efficacy, or the lack of regulation of those practising the therapies. Recent research shows that this remains central to the concerns of influential figures within UK orthodoxy [1].

Until recently the result of such doubts has tended to be institutional standoff. This was exemplified by the position of the British Medical Association (BMA), the primary representative body of orthodox UK physicians, whose published opinion remained unequivocally dismissive of the alternative therapies into the 1980s [2]. However, against a background of continuing public interest, the existence of cross-sectoral collaborations at the level of the professionals [3] and the evident professionalization projects of the complementary therapies themselves [4], the 1990s have seen the publication of a new BMA report which, instead of dismissing the alternative sector, seeks to engage with it [5]. The result is a report which provides a number of precise recommendations about the kinds of quality mechanisms complementary therapies should adopt, mechanisms which owe much to established mainstream practice. It is against this background that the objectives of the project under discussion were defined and the research conducted. These objectives are:

(1) To identify the level of acceptance amongst currently active non-orthodox practitioners in the UK for the principle of BMA participation in the formulation of practice guidelines for complementary medicine.

(2) To identify the level of support for individual proposals drawn from the report.

(3) To identify similarities and differences between the attitudes of practitioners of selected non-orthodox therapies to these proposals.

DESIGN

A postal survey of 1000 practising UK non-orthodox practitioners was conducted after pilot-testing with six alternative practitioners (2 chiropractors, 1 osteopath, 1 homeopath and 2 multi-therapy specialists) in Yorkshire, England. Results were analysed both in aggregate and divided by individual therapy. Data were subjected to weighted statistical analysis (to take account of the

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varying response rates); Chi square and Cramer's V tests were employed.

**SETTING**

The setting was northern England, in the UK between late 1993 and early 1994.

**STUDY PARTICIPANTS**

A tightly defined research population was employed, that is, current UK practitioners of chiropractic, "lay" homeopathy, (as distinct from homeopathy practiced by those qualified in orthodox medicine), medical herbalism, and reflexology, who are also members of at least one national representative body. Clear parameters for inclusion were set because identification of the complete population of alternative practitioners in the UK was not possible. This is because individuals can and do, operate independently of organisations and registers. Moreover, which therapies can be classified as "alternative" is open to debate. It is, therefore, not possible to establish an accurate sample of this population and the reliability of data collated from such a source would be correspondingly weak.

Systematic sampling (every nth practitioner) was used to select 250 respondents per therapy from alphabetical membership lists of the relevant representative bodies. Within each therapy practitioners had an equal probability of selection. The response rate was 57% or 546 respondents (a small number of the original sample had retired or had ceased practicing for other reasons). The response rate varied between the four therapies as follows: homeopathy (62%), chiropractic (58%), medical herbalism (44%), reflexology (54%). The geographical origins and gender composition of respondents and non-respondents were compared; no significant differences were revealed.

**RESULTS**

The principle of orthodox participation in policy formation

The likely success of any argument is, in no small measure, dependent upon the legitimacy which is given to the source of that information. Consequently, practitioners were asked to assess in principle (disregarding actual proposals) their attitude to the involvement of the BMA in the clarification of good practice for the non-orthodox sector.

Despite the historical difficulties which have formed a part of cross-sectoral relations, there is little or no evidence of uncompromising opposition to BMA participation per se. In fact, a mere 4.8% identified with the most negative position, that "the view of the BMA is irrelevant". However — and this is of some importance — failure to unequivocally reject participation by this orthodox institution cannot be equated with uncompli- cated subservience to its pronouncements. Despite the low levels of rejection noted above, still fewer respondents (2.6%) were prepared to accept a "major" role in policy formulation for the BMA. At the level of principle at least, extreme judgements of both kinds were out of favour.

For the great majority of respondents, tempered conclusions held sway. Despite a small number of "Don't knows", 87.7% of respondents allied themselves with a position that accepted a legitimate voice for the BMA but also prescribed definite limits on that participation. In other words, respondents were pointing to the acceptability and appropriateness of the BMA input in quite substantial numbers, but not in a way which would permit the BMA's role to become the determining one.

**Appraisal of the report and its proposals**

By the time they were asked to respond to the research questions, 149 respondents had read the report. Their overall assessment of it confirmed an interesting trend. Despite the shift from a large sample size to a small one and from discussion of a matter of principle to consideration of a matter of concrete reality, the tendency to avoid extreme judgements was repeated in this sub-sample of the population. Not a single respondent felt that the report should be "entirely disregarded". Just 6.5% saw "little merit" in it, with only a further 5.2% expressing "indifference". In keeping with the emerging picture, there were few unreservedly positive comments. However, the response "a positive report to be entirely welcomed" with a rate of 15% received a substantially higher level of support than any individual negative comment. "A report with some merit", the position midway between the two extremes, acknowledging the report's utility but indicating only a partial affinity with it, received the support of 73.2% of the respondents.

Bearing in mind the impracticality of including every facet of the report, the researchers selected six proposals dealing with the range of issues encountered during the formulation of a quality strategy. The six proposals included in the questionnaire also ensured that data would be gathered from the widest possible respondent base, irrespective of whether the original report had been read. The proposals included potentially contentious as well as less controversial material; familiar topics and those that may be new to many respondents.

Table 1 details the overall reactions to each proposal. Fig. 1 shows the response patterns for each of the therapies.

All proposals received majority support. However, substantial pockets of disagreement with particular recommendations were found. Although there was a large measure of consistency across the respondent groups, significant differences emerged on certain key issues.
TABLE 1. Assessment of selected report recommendations by all alternative practitioner respondents

<table>
<thead>
<tr>
<th>Proposal</th>
<th>Agree</th>
<th>Disagree</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. [Each therapy should have] “a single register of members, open to public scrutiny, entry to which is limited to competent practitioners”</td>
<td>90.2</td>
<td>6.8</td>
<td>3.0</td>
</tr>
<tr>
<td>2. [Each therapy should establish] “clearly understood areas of competence, including limits of competence and contra-indications of treatment”</td>
<td>75.7</td>
<td>19.2</td>
<td>5.1</td>
</tr>
<tr>
<td>3. “All practices claiming to have a therapeutic influence should include in their training courses a foundation in basic [mainstream] medical sciences”</td>
<td>80.4</td>
<td>16.4</td>
<td>3.2</td>
</tr>
<tr>
<td>4. [There should be] “training in clinical audit, so that practice, and management of patients, are evaluated rigorously at regular intervals”</td>
<td>59.7</td>
<td>18.6</td>
<td>21.7</td>
</tr>
<tr>
<td>5. “Therapists should not alter the instructions or prescriptions given by a patient’s practitioner without prior consultation with the doctor”</td>
<td>66.9</td>
<td>27.4</td>
<td>5.7</td>
</tr>
<tr>
<td>6. “Consideration should be given to the inclusion of a familiarisation course on non-conventional therapies within the medical undergraduate curriculum.”</td>
<td>92.9</td>
<td>4.1</td>
<td>3.0</td>
</tr>
</tbody>
</table>

Summary of results

The proposal for a single register met with almost unanimous approval, and although disagreement was three times as great with the potentially more contentious proposal to define and limit areas of competence, it too retained substantial support. As with the first proposal, no significant differences were found between respondent groups.

The first recommendation to receive such varied response rates was the proposal to include basic training in orthodox medical sciences as part of the education of alternative practitioners (see Fig. 1). The overall acceptance level of 80% conceals marked differences between the groups. Homeopaths and chiropractors almost universally accepted the proposal, as did large numbers of herbalists. For reflexologists, however, the level of agreement dropped to little over half.

The subject of clinical audit induced clear differences of opinion between the respondent groups. Once again, chiropractic (81% in favour, 5% against) and reflexology (44% in favour, 31% against) represented the clearest division of opinion (Chi square = .00000; Cramer’s V = .39). The relevant figures for homeopathy were 53.6% and 19.6%; for herbalists 59.4% and 19.8%.
The challenging proposal concerning changes to the instruction of orthodox practitioners provided a further point of differentiation between the groups. In total, over a quarter of respondents were not prepared to accept such a restriction on their autonomy. However, rejection levels varied across the groups: reflexology (7%), chiropractic (26%), herbalism (38%), homeopathy (40%).

No such doubts or divisions were expected on the last recommendation selected — that of including some training in non-orthodox practices in the mainstream curriculum — and none were found. Endorsement of this recommendation was broadly based.

DISCUSSION

The first objective of the study was to determine the level of acceptance for the principle of BMA participation in policy formation. What is clear from the results is that the institutional revisionism of the BMA is finding a potentially receptive audience at the level of the individual complementary practitioner. The preparedness of the vast majority of practitioners to accept the legitimacy of BMA participation in debate about the future of practice and regulation of that practice, establishes a positive context within which to work. However, the almost universal rejection of a major role for the BMA demonstrates that the BMA is seen as an external interest group whose participation is accepted, but not necessarily as the source of definitive input.

At the level of principle, a picture of guarded openness emerges. The position regarding individual proposals (the second objective) requires rather closer attention to the specifics of the issues involved. Initially, two conclusions must be drawn about the results that relate to these proposals.

Firstly, it is not simply the source, but rather the content, of the proposals that is shaping rates of acceptance. The lack of uniformity in the approval granted to various proposals indicates that they are being judged on their merits and not merely as a consequence of their origins. Secondly — and this is of particular importance bearing in mind the third objective of the work — the differing response patterns reveal the varying concerns, emphases and priorities of the different therapies.

In short, intra-sectoral differentiation is observable in the data. It is not that particular practitioner groups can be categorized as entirely positive or entirely negative toward the proposals. The differences are issue-specific. The fact that a given therapy contains a high proportion of practitioners unhappy with one proposal does not lead to an automatic rejection of other measures. Such a finding is not only central to an understanding of the attitudinal make-up of this diverse sector but also highlights the complexities involved in identifying acceptable definitions and mechanisms of quality. The results relating to each proposal should be discussed separately.

Broad acceptance of a single register is consistent with the move of contemporary complementary medicine toward professionalization. Registration is now an established element in achieving recognition of the professions’ status in the mainstream. It does not constitute a major infringement on practitioners’ autonomy but provides discernible benefits for the individuals and therapies involved, most notably in protecting registered individuals from the charge of “quackery”.

The proposal to limit areas of competence is potentially more threatening. This is reflected in the finding that disagreement with this proposal was approximately three times as high as the level of disagreement with the first proposal. However, the overwhelming majority of members in each therapy accepted this recommendation. Definition of the scope of a particular therapy will provide the foundation on which later measures of quality of care — not least those concerning the effectiveness of treatment — can be based. It is evident that amongst practitioners there is an openness to dialogue on this subject.

The difference between the therapies in their responses to the first two proposals was not statistically significant. By contrast, the findings on the subject of including basic training in orthodoxy medicine in the training of alternative practitioners were. Here an understanding of the diverse nature of the therapies grouped together as “alternative” — in particular the existing programs of training — becomes necessary. The training requirements for chiropractic and reflexology clearly highlight these differences and demonstrate that these therapies are completely different from each other [5]. The former requires pre-course qualifications in traditional sciences and takes a number of years to complete; the latter is virtually open to all and training is of much shorter duration. The key point is that the proposal under discussion would make much greater demands for change on reflexology. In this context, the responses from chiropractic professionals (the most positive) and reflexology practitioners (those least positive), constituting the extremes of reaction to this proposal, can be understood. While this practical dimension cannot be seen as the only process at work here (the difference between herbalists and other groups is less easily understood in these terms and the philosophical clash of perspective should not be overlooked), the varying practical impact which specific measures induce in specific settings is certainly a factor which will impinge on its potential for integration into practice.

The results relating to clinical audit are important for two reasons. They provide the lowest level of acceptance amongst the selected proposals (although the relatively large number of “Don’t know” responses was influential in this) and they demonstrate a further and dramatic point of variation between the groups. The variation both within and between groups confirms the importance of establishing precise evidence for the various responses from the different respondent groups. For a large minority of the practitioners the concept of clinical
audit is meaningless; it is beyond their experience. Before
the question of consent to such mechanisms can be
addressed, the matter of awareness and understanding
needs to be raised.

Of all the proposals listed, the proposal concerning
changes to the instruction of orthodox practitioners
appears to be of greatest importance. This issue brings
concerns about an autonomous or supplementary status
and about a parallel or supportive practice, into sharp
focus. All future decision making on quality will
necessarily relate to these matters. Substantial diversity
of opinion was expressed. In this case however, the
proposal was particularly problematic for homeopathic
practitioners and for herbalists. It is important to under-
stand the setting into which these proposals are to be
introduced. The philosophy and objectives of some of
these therapies are more orientated toward a stand-alone
position and there is a greater affinity with independent
decision making. The different levels of concern with the
challenge to therapeutic autonomy are certainly sug-
gested by the data. For example, amongst reflexologists
the level of concern is slight; amongst homeopaths there
is almost an even split. The character and priorities of
individual therapies are all important.

The idea of including non-orthodox practices in
orthodox training was seen as beneficial by virtually all
respondents. There were no therapy-specific concerns
with this proposal.

It is certainly the case that a conceptualization based
on two opposing and distinct camps is no longer
appropriate. Just as the BMA is looking to engage with
complementary practitioners on the way forward for
institutionalizing quality of care, so too the practitioners
themselves are evidently prepared to consider proposals
from beyond their own sector. A willingness to formalize
arrangements to ensure appropriate standards of care
and to address the long-standing criticisms of comple-
mentary medicine is present. The key task will be to
marry this with the concerns — for example, with the
autonomy — of practitioners with a very clear sense of
their therapeutic role.

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