

Signalling and the quest for regulation in British complementary medicine¹

Jure Stojan

DPhil Student, St Antony's College, University of Oxford

Abstract

Regulation seeking is a central interest of regulatory economics. This paper addresses the issue from an economic historical perspective, considering the regulation of British osteopaths and chiropractors. The study of regulatory motivation requires more precise research questions: 'Why was a particular form of regulation sought at the time?' It is suggested that the osteopaths' early campaign for regulation during the 1920s and '30s did not have the objective of obtaining statutory regulation. Rather, it was instrumental in uniting various factions of qualified practitioners and moreover, used as a signalling device. The renewed osteopathic interest in statutory regulation in the 1980s is interpreted as a function of the changing effectiveness of market signalling. Accordingly, the problem of whether or not to regulate is analysed as a function of its economic context. Both complementary professions operate within the medical market characterised by asymmetrical information and their regulation can be thus understood as the control of market signals. The Osteopaths' choice of self-regulation is treated as a signal in its own right, being a part of the integrated 'signalling mix'. This included upper class patronage, fashionable addresses of osteopathic practices, self-imposed restrictions on advertising, and the 'cosmetics of professionalisation'—signals imitating those of the medical profession. Osteopaths continuously relied on upper class patronage, a common signalling device within the medical market.

¹ The author wishes to thank Professor Avner Offer for his invaluable comments on an extended version of this paper. Professor Bob Allen asked some insightful questions about signalling in complementary medicine. The author, though, is the one responsible for any errors. The paper is based on research funded by the ESRC grant PTA-031-2004-00352.

'Cosmetics of professionalisation' was an inexpensive signal, used by high and by low quality competitors alike. Subsequently, its usage was curbed with successful legal actions by the medical profession. The signal of legislative attention acquired in the 1930s sufficiently strengthened the qualified osteopaths' 'signalling mix' so that they felt able to eschew statutory regulation up to the 1980s.

Introduction

This paper proposes that the demand for regulation of British complementary medicine has been tactical and variable in nature. Moreover, it holds that this is explainable by the diminishing effectiveness of market signalling. The two professions it analyses—osteopathy and chiropractic—are the two benchmark cases of British complementary medicine.

When Parliament passed the Osteopaths Act in 1993 and the Chiropractors Act in 1994, osteopathy and chiropractic became the only two branches of complementary and alternative medicine in Britain which have so far achieved statutory regulation. This is remarkable, especially considering that both professions date back to the late nineteenth century. At first glance, this appears to be a culmination of careful lobbying of almost eighty years. Osteopaths first attempted to achieve state regulation in the 1920s. In 1925, the British Osteopathic Association (BOA) sent a deputation to the Minister of Health. The House of Commons dropped the Regulation and Registration of Osteopathy Bill three times, in 1931, 1933, and 1934. The Bill was subsequently introduced in the Lords, where it had received a second reading before being referred to a Select Committee and

finally withdrawn. After the collapse of the Osteopathy Bills—partially because of fierce opposition from the medical profession—osteopaths opted for self-regulation and established the General Council and Register of Osteopaths (GCRO). Early attempts by chiropractors to secure statutory regulation, even to achieve basic professional organization, were direct reactions to osteopathic regulatory campaigns they perceived as a threat to chiropractic practice. Even if they started reactively, chiropractors soon adopted a proactive stance in seeking statutory regulation. Eventually, developments in the 1980s led to State recognition of both professions.

Such a summary fits the standard Chicago school theory of regulation well. The osteopathic industry demanded regulation and when in the late 1980s the balance of power tilted to its advantage, it finally managed to acquire regulation. Economic history of osteopathic regulation seeking, however, shows that their demand was far more variable than it is accounted for by standard economic theory. Moreover, it takes much of market signalling—the public demand for regulation—at face value. The management scholar Michael Porter, however, argues that market signalling is tactical and potentially deceiving.²

Tactical signalling

In the period before the Second World War, osteopaths were facing two options: either they opted out of the market for alternative medicine (by obtaining statutory regulation) or they improved their position within it (by obtaining better signals). The issue therefore revolves around the

objective of seeking legislation. Was statutory regulation really the desired outcome of this process?

The question is counterintuitive, especially considering that early osteopaths spared no effort in voicing their desire to get regulated. Indeed, lobbying for legislation was deemed a central task of the British Osteopathic Association and defined in its Constitution.³ Some observers in the 1930s, however, were baffled what advantages a profession as young as osteopathy expected to draw from statutory regulation. Its main competitive advantage was believed to be precisely its unqualified and unorthodox nature.⁴

There are two ways how to tackle this issue of motivation behind regulation seeking. Firstly, one might take a look at the benefit osteopaths might derive from the regulation-seeking process itself, even if it failed. If the benefits exceeded the costs incurred by expensive and time-consuming lobbying, it was only rational to initiate it.

The first hypothesis states that regulation seeking was a device to unite different factions within the profession and thus help qualified osteopaths to eliminate internal price competition (while making it easier to differentiate between them and the unqualified practitioners). The 1930s saw less than 200 qualified osteopaths, whilst the number of their unqualified competitors was estimated to approach 2,000.⁵ In order to differentiate their services, qualified osteopaths had an incentive to

² Porter, *Competitive strategy*, 76.

³ Wellcome S/BOA/1.

⁴ Hill & Clegg, *What is Osteopathy?*, 186.

⁵ *The Times*, 16/3/1935, 14.

overcome their internal divisions—in the period before the quest for regulation, they had been split along the lines of education. Graduates of approved American osteopathic colleges were organised into BOA and considered to be the superiorly trained practitioners. While they considered British School of Osteopathy (BSO) to be ‘the only reputable school’ in Great Britain, they did not regard its standard to be satisfactory.⁶ Its graduates therefore formed of the Incorporated Association of Osteopaths (later the Osteopathic Association of Great Britain, OAGB).⁷ The lowest ranking qualified osteopaths were represented by the National Society of Osteopaths (NSO), ‘whose members held diplomas from other training establishments, since defunct, or had acquired their proficiency by means of apprenticeship perfected by long practice.’⁸ In order to press for statutory regulation, the first two strata of qualified osteopaths formed a coalition. The Osteopathy Bills were promoted by BOA, the Incorporated Association of Osteopaths, BSO, and the Osteopathic-Defence League (representing osteopaths’ patients yet presided over by Wilfred Streeter, a noted BOA member).⁹ Moreover, the qualified osteopaths continued to cooperate even after the failings of the Bills. When the self-regulative body, The General Council and Register of Osteopaths (GCRO), was formed in 1936, it was established by all three professional organisations.¹⁰

⁶ *The Times*, 6/4/1935, 18.

⁷ GCRO, *The Osteopathic Blue Book*, 25.

⁸ cf. *ibid.*

⁹ cf. *ibid.* 14.

¹⁰ cf. *ibid.* 25.

The second proposition is that the osteopaths used the process of regulation seeking to generate legislative and media attention—additional signals that improved osteopaths’ position in the market. The legislative attention was indeed used as a signalling device, even decades after the failing of Osteopathy Bills. The ‘Preface’ to the annual *Directory of members* stated that the Register of Osteopaths was ‘a voluntary body constituted in the year 1935 on the recommendation of a Select Committee of the House of Lords.’¹¹ This reference to the Bills was dropped only in 1964.

One might also look at the probability that regulation-seeking behaviour actually results in statutory regulation. If the process was initiated with a belief this probability was low, then statutory regulation was not the true objective. As a matter of fact, some osteopaths admitted that the demands set forth in the Bill proposal were ‘somewhat excessive.’¹² Even more, osteopaths’ solicitors did not believe that 1931 Bill was achievable.¹³ Lastly, it was clear from the very onset that introducing the 1934 Bill was a futile undertaking. Not only did its wording closely follow the two preceding Bills, it was also introduced in almost unchanged circumstances. The government had kept its principal objections to the Bills—that they would unduly elevate a mere theory of healing and that they would prevent mainstream physicians from

¹¹ e.g. GCRO, *Directory of Members 1958*, 3.

¹² McKeon, *Osteopathic Polemics*, 104.

¹³ D. MacAlister to G. Newman, dated 25/3/1931. PRO, MH 58/107.

performing osteopathic techniques.¹⁴ The Ministry of Health officials thus had no difficulties arranging the Bill to fail.¹⁵

The Bills introduced in the House of Commons did not yet reach the whole publicity-generating potential of regulation seeking. For example, the 1931 Registration and regulation of Osteopathy Bill did not generate much parliamentary debate and was withdrawn after the Order for Second Reading had been discharged.¹⁶ The 1933 and 1934 Bills were similarly inconspicuous. However, this situation changed when the Bill was introduced in the House of Lords in December 1934.¹⁷ Subsequently, the Lords appointed a Select Committee that considered the Bill in twelve sessions, examining twenty witnesses.¹⁸ Their inquiry received extensive media coverage and osteopaths themselves stressed the importance of the attention they had received—they believed it was ‘the first time that any responsible person in this country has ever been willing to investigate osteopathy.’¹⁹

Osteopaths withdrew the Bill during the Lords inquiry. Even so, the Select Committee reported that osteopathy did not meet the necessary requirements for obtaining a statutory register.²⁰ Nonetheless, the osteopaths chose to interpret the Lords’ criticisms as ‘recommendations’ and used the inquiry as a signalling device.

¹⁴ e.g. A.N. Rucker to L.L.H. Thompson, dated 8/5/1931. PRO, MH 58/107

¹⁵ A.N. Rucker to C.J. Harris, dated 22/2/1934. PRO, MH 58/107.

¹⁶ *Hansard*, Commons, vol. cclii, 1160.

¹⁷ *Hansard*, Lords, vol. xcv, 186.

¹⁸ *Report from the Select Committee of the House of Lords appointed to consider the Registration and Regulation of Osteopaths Bill*, 2.

¹⁹ Cf. *The Times*, 23/3/1935, 7.

²⁰ *Report from the Select Committee*, 2.

The Second World War brought about a change in osteopathic regulation seeking. The GCRO lobbied for regulation once more in 1944 and sent a deputation to the Minister of Health—at a time when the Ministry of Health was already discussing plans for the National Health Service. At this point it became clear that at least one osteopathic organisation had not wanted statutory recognition. In July 1944, Ministry of Health officials received a separate delegation of BOA. It resented the idea that osteopaths should organize themselves as a step towards State registration; it asked for ‘some kind of official mandate’ to organize osteopathy. Moreover, it became clear that the Association regarded ‘itself as representing a small corps d’élite of the better qualified osteopaths’. BOA opposed any statutory register that would have included members of competing osteopathic organizations. ‘Osteopaths in general [...] will tend to throw registration wide enough to include semi-qualified and the quacks, and so the interests of most of those on any register will be to oust the few Obetter qualified.’²¹

Change of demand

After the Second World War, osteopaths seemed to be satisfied with self-regulation. This was all too apparent since lay supporters of osteopathy continued to press for regulation. The public, it seems, demanded protection from bogus osteopaths, invoking the public interest rationale for regulation. However, it is probable that these calls were directed by osteopaths of lesser rank, excluded from the General Council and Register

²¹ Minutes, dated 10/7/1944. PRO, MH 135/774.

of Osteopaths. Barred from using the signal of self-regulation, they might have considered statutory regulative body a more inclusive alternative to the exclusivist and elitist self-regulator.

In 1953 the Hampstead Housewives' Association publicly appealed for 'state recognition of osteopaths'. Subsequently R. F. Miller, the registrar of the GCRO, informed the Ministry of Health that it was not the policy of the General Council 'to seek any change at present in the status of Members of the Register of Osteopaths; nor do they desire to be associated with attempts to hasten any change.'²²

Still, the calls for recognition and regulation persisted. At their annual conference of 1954, the Co-operative Party passed a resolution requesting 'recognition and inclusion of Osteopathy as a part of the National Health Service'.²³ A similar resolution was also passed in 1962.²⁴ Still, the main osteopathic professional bodies remained firm supporters of voluntary self-regulation and publicised this position.²⁵

When Mrs. Joyce Butler, MP introduced her failed Osteopaths Bill in April 1976, this came 'to the surprise of many within the osteopathic profession'.²⁶ Again, the protection of the public was cited as the objective of regulation.²⁷ David Owen, Minister of State for Health and Social Services, subsequently cautioned Mrs. Butler that the 'Osteopaths are divided among a number of organizations and [...] that only one favours

²² Letter, dated 16/12/1953. PRO, MH 135/774.

²³ Co-operative Party to the Ministry of Health, dated 27/5/1954. PRO, MH 135/776.

²⁴ Ministry of Health to the Co-operative Party, dated 14/6/1962. PRO, MH, 135/776.

²⁵ *The Osteopathic Blue Book*, 55–6.

²⁶ Fielding, 'Osteopathy,' 250.

²⁷ *The Times* 8/4/1976, 10.

statutory registration at this junction. The largest organisation, the General Council and Register of Osteopaths Limited maintains that a statutory register is unnecessary and superfluous since its own register [...] provides all that is needed.’²⁸ Unfortunately, surviving Ministry of Health files do not contain information on which osteopathic organisation lobbied for statutory regulation.

The stance of the majority of osteopaths was publicly reaffirmed, the same year, by Lord Cullen of Ashbourne, Chairman of the Osteopathic Educational Foundation. In a Lords debate, he said: “My lords, may I make it clear that, as far as I know, the osteopathic profession does not want to be included in the same way as the chiropractors evidently do. They are very happy with the arrangement as it now stands.”²⁹ When chiropractors intensified their campaigns for statutory regulation in the 1970s, the members of the GCRO refused to eschew voluntary self-regulation.

However, the GCRO and its constituent organisations did not stand for the whole of the osteopathic profession, even though it represented high quality practitioners and was consequently the most influential osteopathic organisation. It is probable that some marginal professional organisations were dissatisfied with self-regulation and that their number was growing.

As it was, the post war years saw increasing competition by new self-regulatory bodies. The Natural Therapeutic and Osteopathic Society and

²⁸ David Owen to Joyce Butler, dated 18/5/1976. PRO, MH 158/395.

²⁹ *Hansard*, Lords, vol. ccclxx, 1037.

Register, as well as the College of Osteopaths, were established already in 1948.³⁰ In 1961, British Naturopathic Association changed its name to become the British Naturopathic and Osteopathic Association (BNOA).³¹ The Osteopathic and Naturopathic Guild was established in 1967, the Guild of Osteopaths London in 1971, the British and European Osteopathic Association in 1976, the Faculty of Osteopathy in 1978, and the Association of Osteopathic Practitioners in 1984.³² Conversely, the GCRO retained the most numerous memberships. In 1988, its register included 1,140 osteopaths practising in the UK, while all the competing registers together totalled 864 lower ranking practitioners.³³

Finally in the late 1980s, osteopaths resumed their regulation seeking. Simon Fielding dates the 'the origins of the final and ultimately successful political campaign for statutory regulation' to 27th February 1985 when the House of Lords debated on natural medicine.³⁴ Subsequently in 1986, Roy Galley MP introduced an Osteopathy Bill to the House of Commons. Commentators agree that the Bill was introduced without hopes for success, as a means of testing political support for regulation of osteopathy.³⁵ In 1987, Lord Cullen of Ashbourne assured the House of Lords that osteopathy had fulfilled all criteria for statutory registration.³⁶ In the same debate, Lord Skelmersdale, Parliamentary Under-Secretary of

³⁰ The Monopolies and Mergers Commission, *Services of Professionally Regulated Osteopaths*, 16.

³¹ cf. 'Note for file' by E.G. Croft, dated 27/7/1961. PRO, MH 135/776.

³² The Monopolies and Mergers Commission, *Services*, 13–7.

³³ *ibid.* 42.

³⁴ Fielding, 'Osteopathy', 250.

³⁵ The Monopolies and Mergers Commission, *Services*, 4; Fielding, 'Osteopathy', 251.

³⁶ *Hansard*, Lords, vol. cdlxxxix, 1404.

State, added that he had met with representatives of osteopaths and that there had 'since been agreement among osteopaths' on the issue of submitting for statutory registration.³⁷

In 1989, King Edward's Hospital Fund formed, following a suggestion made by the Prince of Wales the previous year, a working party on osteopathy. Its report, published in 1991, recommended statutory regulation of osteopathy. This was believed to assure standards of training, make standards of professional conduct enforceable, establish a suitable mechanism for dealing with complaints against practitioners, and guarantee 'that all practitioners are fully covered by professional indemnity insurance.'³⁸ In 1992, an Osteopaths Bill was introduced to the House of Lords by the retired president of the General Medical Council, Lord Walton. The Bill was supported by the House of Lords and the Government, but was not proceeded with because of the general elections. Finally in January 1993, Malcolm Moss MP introduced the Osteopaths Bill. The Private Member's Bill 'achieved all party and government support and completed its passage through Parliament, receiving Royal Assent on July 1 1993.'³⁹

This course of events shows that in the 1980s, osteopaths changed their preferences. Whereas they had preferred voluntary self-regulation, they suddenly felt that statutory regulation might suit them and their patients better.

³⁷ *ibid.* 1414.

³⁸ Fielding, 'Osteopathy,' 251.

³⁹ *ibid.* 252.

The changing signalling mix

Economic theory holds that in order to prevent being driven out of the market, sellers with high quality products or services have the greatest incentive to use signalling devices. However, if a signal proves to be successful, 'the incentive will trickle down through the spectrum of qualities.'⁴⁰ The signal (eventually used even by the bogus osteopath) will consequently become ineffective for the high quality seller (i.e. the more intensively trained, medically orientated osteopaths). Furthermore, an effective signal must be 'unprofitable for sellers of low quality products to imitate it. That is, high quality sellers must have lower [not necessarily financial] costs for signalling activities.'⁴¹

Voluntary self-regulation is a signal—when other signalling devices are prohibitively costly, not credible, 'or even excluded in certain markets', there is an incentive to self-regulate.⁴² The osteopaths might have chosen to exchange it for an even stronger signal (for statutory regulation) because they needed to adopt their 'signal mix' to new market challenges (while some of their signals lost its effectiveness). Moreover, there was a rising competition among osteopathic self-regulatory bodies as these organisations proliferated. This called for a change in the osteopathic 'signalling mix.'

Apart from osteopaths' self-regulation, their 'signalling mix' included upper class patronage, fashionable addresses of osteopathic practices,

⁴⁰ Spence, 'Informational aspects,' 592.

⁴¹ *ibid.*

⁴² Gehrig & Jost, 'Quacks, Lemons, and Self Regulation: A Welfare Analysis,' 309-25.

self-imposed restrictions on advertising, and what one might call the ‘cosmetics of professionalisation’—ambiguous signals used by alternative medical professionals that imitate those that are legally restricted to the medical profession (the likeliness is sufficient to evoke conventional medicine, the difference adequate to avoid prosecution). The ‘signalling mix’ was integrated. Indeed, the boundaries between two or even more categories of signals were sometimes flux.

Upper class patronage

Upper class patronage was a complex signal having two major aspects. To begin with, when Osteopaths treated upper class patients, this not only enabled them to charge premium fees but also was a signal of respectability. Moreover, Osteopaths relied on their clientele’s political support in regulation seeking.

Using of upper class patients as a signalling device has a long history within the medical market. It predates osteopaths for several centuries. Indeed, ‘anyone wishing to soar as an unorthodox healer had to look to prestigious lay patronage’.⁴³ This signalling device was based on what Brian Simpson calls an ‘appeal to the snobbery’ of prospective patients. In fact, publishing lists of eminent patients and of their ‘testimonials, which could be fraudulent, was standard practice in the quack medicine world’.⁴⁴

However, osteopaths’ self-imposed restrictions on advertising meant that upper class patient lists were not used as extensively as in other,

⁴³ Porter, *Quacks*, 100.

⁴⁴ Simpson, *Leading Cases*, 265.

older, branches of alternative medicine. Even though their own code of ethics prevented osteopaths from disseminating information on their eminent patients, this restriction did not apply to their clientele. As it was, many upper class patients made favourable public statements on the value of osteopathy, including Queen Elizabeth, the Queen Mother.⁴⁵

Osteopaths relied far more on the second aspect of upper class patronage, namely on the political support. This signal conveyed respectability of the evolving profession. For this reason, the General Council and Register of Osteopaths was presided over by an eminent peer.

Fashionable addresses

Observers in the 1930s did not fail to notice the locations of osteopathic practices. When osteopaths were practicing in cities, they were most likely to be based in prestigious areas. This was especially striking in the capital. 'According to the 1934 Directory [of BOA], of the thirty-nine members practicing in London thirty-four have a West-End address.'⁴⁶ Fashionable addresses did not only ease access to lucrative upper class patients. Above all, they were a very strong signal of respectability and quality. This was especially true for practices on Harley Street in London or in its immediate vicinity. However, osteopaths found it increasingly difficult to obtain lease for such premises.

As early as in 1935 the Howard de Walden Estate did not allow osteopaths to practice on its premises in Harley Street, but in side streets

⁴⁵ Murray, *Frontiers of Healing*, 80.

⁴⁶ Hill & Clegg, *What is Osteopathy?*, 197.

if they produced evidence of ‘having the best diploma obtainable,’ at the complete discretion of the estate.⁴⁷ This policy remained unchanged well into the second half of the twentieth century and in the 1960s, only very few osteopaths—‘possibly 2 or 3’—were practising in Harley Street. This was explained as a ‘hang-over from the war, when a few osteopaths became established and the Estate decided not to take positive action to get rid of them, but to rely on the passing of time.’⁴⁸ Another possible factor making osteopaths undesired tenants might have been the Profumo affair of 1963. It turned out that the American-educated osteopath Stephen Ward had used his practice in Devonshire Street, off Harley Street, to run a call-girl ring catering the needs of the political and diplomatic elite.⁴⁹

Crown Estate Commissioners were initially happy to accept fashionable osteopaths as tenants. By 1935, however, the opposition against osteopathy had hardened. Some Crown Estate Commissioners were ‘strongly averse to unqualified men, with or without misleading degrees of “Dr” granted by irresponsible institutions, being allowed to practice in Crown houses, especially in the neighbourhood of registered medical practitioners.’⁵⁰

After the war, the Crown Estate decided to consider each application from an osteopath on its merit. However, the Commissioners felt that this had ‘really proved unworkable’ and apart a few exceptions, applications

⁴⁷ ‘22 Ulster Place,’ dated 25/1/1935. PRO, CRES 35/4966.

⁴⁸ ‘Harley Street,’ dated 23/12/1969. PRO, CRES 35/4966.

⁴⁹ e.g. *The Times* 26/7/1963, 8a.

⁵⁰ *ibid.*

from Osteopaths had 'always been turned down'.⁵¹ Osteopaths were finally excluded in 1969, when an unsuccessful applicant enlisted the support of Mrs. Joyce Butler, MP who triggered a review of the Crown Estate letting policy.⁵²

Subsequently, Crown Commissioners consulted the British Medical Association and were advised 'quite unofficially but in the strongest terms' that Harley Street should be kept for statutory recognized professions only.⁵³ This recommendation was accepted. Moreover, the Commissioner discovered that four osteopaths were indeed practicing in the said area and decided evict them.⁵⁴

It was therefore the medical profession's bargaining power that gradually limited the availability of fashionable addresses to osteopaths, until they became unavailable in 1969. Another factor that led barred osteopaths from using this signal was the internal schism between the General Register of Osteopaths (GRCO), which the Commissioners considered respectable, and the British Naturopathic and Osteopathic Association (BNOA), held to be dubious. It was decided that accepting GRCO members would bring the Crown Estate into undue conflict with the BNOA. Moreover, it was the latter organisation that most likely provided applicants for Harley Street consulting rooms.⁵⁵ It was therefore the less respected group that had the greatest demand for this expensive

⁵¹ 'Extract from notes', dated 12/6/1969. PRO, CRES 35/4966.

⁵² J. Butler to J.A. Sutherland-Harris, dated 22/5/1969. PRO, CRES 35/4966.

⁵³ 'Harley Street', dated 20/10/1969. PRO, CRES 35/4966.

⁵⁴ W.A. Wood to J. Butler, dated 8/1/1970. PRO, CRES 35/4966.

⁵⁵ *ibid.* 4

yet very effective signal. Such spreading of signals ‘through the spectrum of qualities’ is predicted by the signalling theory.⁵⁶

‘Cosmetics of professionalisation’

To start with a very appearance-based example of ‘cosmetics of professionalisation’, the British Chiropractors’ Association used a logotype imitating that of the British Medical Association. Moreover, the names of osteopathic and chiropractic organisations alike were carefully following the medical example. For example, the appellations British Chiropractor’s Association (BCA) and the British Osteopathic Association (BOA.) closely echoed the name of the central medical professional body, the British Medical Association (BMA).

More legally problematic were osteopathic titles and designations. Most blatantly, members of the Incorporated Association of Osteopaths used the title ‘Osteopathic Physician and Surgeon’. This was prohibited only after an appeal to the King’s Bench, in the *Whitwell v. Shakesby* ruling (1932).⁵⁷ This signal was thus emulating one statutorily restricted to the medical profession.

Self-imposed restrictions on advertising

In healthcare, advertising has long been associated with goods or services of dubious quality. The reason for this lies in both ends of the market. While quack medicines have been heavily promoted, orthodox doctors

⁵⁶ cf. Spence, ‘Informational aspects,’ 592.

⁵⁷ *Whitwell v. Shakesby* (1932). *The Times*, 12/5/1932, 4.

have been barred from advertising by the medical code of ethics.⁵⁸ By choosing not to advertise, a complementary profession hence evokes mainstream respectability.

When pre-war osteopaths decided not to advertise, they were signalling professionalism by following the example of other professions. An osteopathic book of the 1930s makes this connection obvious: 'As in other respected professions, the qualified osteopath does not advertise. The results which he obtains advertise themselves.'⁵⁹ Besides, some osteopaths believed that this would strengthen the signal provided by the voluntary self-regulation and education. If osteopaths did not engage in mass advertising, so the logic went, they signalled professional confidence that underscored their educational qualifications.⁶⁰

Furthermore, restrictions on advertising were mandatory for those osteopaths who wanted to practise in prestigious areas of London. In the 1930s, Crown Estate Commissioners stipulated that osteopaths occupying Crown property 'do not advertise in the public press.'⁶¹

Nonetheless, these restrictions on advertising were self-imposed and osteopathic bodies had thus only limited means of enforcement. If an osteopath had been expelled from one organization, he or she would probably find membership in a competing professional body. For example, in the 1930s the British Osteopathic Association started an internal investigation against one of its members for publicly advertising

⁵⁸ Simpson, *Leading Cases*, 284.

⁵⁹ McKeon, *Osteopathic Polemics*, 32.

⁶⁰ Darlison, *The new art of healing*, 44.

⁶¹ '22 Ulster Place,' dated 25/1/1935. PRO, CRES 35/4966.

one of his books. The osteopath subsequently quit the Association and joined the Incorporated Society of British Osteopaths.⁶² Restrictions on advertising were therefore a rather inefficient signal, at least in the decades before the Second World War.

While the self-imposed restriction on advertising was inefficient in the short run, it turned out to be a rational move in the 1980s. When the Monopolies and Mergers Commission investigated the effects of advertising restriction on the public interest, 12 osteopathic bodies were found to limit their members' marketing communications. Most of them permitted advertising only when setting up a practice, when changing address or through directory entries, all in approved forms.⁶³ Therefore, if an osteopath wanted to advertise freely he or she had to remain outside professional bodies, even though they were competing for members. Switching from one organization to another could no longer be used as a means of circumventing advertising restrictions.

Secondly, restrictions on advertising contributed to an improved reputation of osteopathy. Even more, they were considered essential for sustaining the improved relations between osteopathy and conventional medicine, which had evolved during the latter part of the twentieth century.⁶⁴

By eschewing advertising, osteopaths were consequently signalling professionalism and helped consumers to differentiate between the genuine and the bogus osteopath. Accordingly, the true practitioners

⁶² cf. *The Times*, 28/3/1935, 4.

⁶³ The Monopolies and Mergers Commission, *Services*, 1.

could charge a higher price. At the same time, it made it hard to differentiate between various genuine osteopaths and thus limited price competition amongst them.

Conclusion

This paper discussed the economic history of regulation of British osteopaths and chiropractors. It focused on historical regulatory motivation and held that the same actor (the osteopaths) can initiate the same activity (regulation seeking) at two different points in time (1930s, 1980s)—with two different sets of motivations. Moreover, it was suggested that the early osteopaths' campaign for regulation did not have the objective of obtaining statutory regulation. It was rather a means of uniting the profession of the 1930s. Moreover, it signalled that osteopathic services are of such value that they deserve parliamentary recognition.

The changing osteopaths' regulatory motivation was discussed under the assumption that alternative practitioners taken as a group were behaving in an economically rational way within the medical market, their changing preferences in regulatory regime being a function of changing effectiveness of signals they were using. Self-regulation is a signal in its own right; the departure from voluntary self-regulatory towards the stronger signal of statutory regulation can be interpreted as a reaction to new market challenges. Apart from osteopaths' self-regulation, their integrated 'signal mix' included upper class patronage, fashionable addresses of osteopathic practices, self-imposed restrictions on

⁶⁴ *ibid.* 18, 25.

advertising, and the ‘cosmetics of professionalisation’—signals imitating those of the medical profession.

Osteopaths had continuously relied on upper class patronage, a common (and consequently less effective) signalling device within the medical market. Therefore, the signal was only reinforcing the others within the mix. ‘Cosmetics of professionalisation’ was an inexpensive signal, used by high and by low quality competitors alike. Furthermore, its usage was curbed with successful legal actions by the medical profession. The latter also succeeded in excluding osteopathic practices from fashionable addresses—a signal that was also losing its effectiveness because of being adopted by competitors of inferior quality.

The signal of legislative attention acquired in the 1930s sufficiently strengthened qualified osteopaths’ ‘signalling mix’ so that they eschewed statutory regulation after the Second World War. Also, the signal of self-imposed restrictions on advertising slowly became effective. However, the task remains to formally model the relationship between various signals from an alternative profession’s ‘signalling mix’. Ideally, the model would provide quantitative criteria—‘thresholds of the signalling mix ineffectiveness’—that a profession must face in order to demand the stronger signal of stricter regulation.

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