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Statutory regulators' views on continuing professional development: A qualitative study of UK osteopathy and chiropractic

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ABSTRACT

Background: Continuing professional development (CPD) is essential in maintaining standards in healthcare. While CPD has been widely studied among practitioners, little attention has been paid to the perspectives of those in regulatory roles. This study explores how individuals involved with CPD at the statutory regulators for chiropractic and osteopathy in the United Kingdom perceive the governance, engagement with, and effectiveness of CPD as currently organised.

Methods: Semi-structured interviews were conducted with ten participants from the General Chiropractic Council (GCC) and General Osteopathic Council (GOsC). These included administrative officers, those with strategic positions, or committee members whose remit included CPD issues, such as those with roles on education committees. Reflexive thematic analysis was used to identify patterns in participants' experiences and perceptions. A constructivist approach informed the analysis.

Results: Two overarching themes were developed: the value of regulators in supporting public safety and reassurance through CPD, and a sense of responsibility for CPD. Subthemes included trust issues with regulators, perceived quality and relevance of CPD, and systemic limitations linked to resources and legislation.

Conclusions: Regulatory staff view CPD as crucial to safeguarding the public and maintaining trust. However, challenges such as resource constraints, professional isolation, and the absence of formal CPD accreditation mechanisms limit its effectiveness. Improved communication and strategic changes may enhance CPD's impact.

Implications for practice

- From these findings, practising clinicians may better understand the role and responsibilities of the chiropractic and osteopathic registration bodies and therefore may engage with them more regularly and effectively.
- Clinicians should consider the types of CPD offerings they undertake, as they may not always be fit for purpose, in terms of addressing the main issues for which the regulators intend: improving safe and competent practice.
- Legislative change may be necessary to improve flexibility in the governance of CPD to respond to changes in practice and the marketplace of CPD offerings.
- Reforms to the CPD systems could potentially improve practice as well as retention on the statutory registers.

1. Introduction

Osteopathy and chiropractic have similar origins; they both arose in the American Midwest in the late 19th century and have founders that have been given iconic status within each profession. For osteopathy, it was Andrew Taylor Still; for chiropractic, Daniel David (DD) Palmer. Osteopathy and chiropractic also have similar histories of their development, having been created as a reaction to the medical methods of the day. Both use spinal manipulation and peripheral joint manipulation alongside other manual therapy approaches. Varying degrees of psychologically informed approaches, activity and exercise promotion and self-management interventions have been added over time. Both survived challenges to their existence to arrive at their current status with independent professional statutory regulatory bodies (PSRB) in the United Kingdom (UK).

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Osteopathy and chiropractic are relatively small professions in the UK. Chiropractic has about 3900 registered practitioners at the time of this writing and osteopathy has about 5,500, in comparison to the 80,000 physiotherapists [1] or 410,000 medical doctors [2]. The General Chiropractic Council (GCC) and General Osteopathic Council (GOsC) regulate their respective professions in the UK. Larger PSRBs such as the General Medical Council (GMC) have speciality bodies to support governance and to ensure supervision of members' practices and reskilling and upskilling to maintain currency with developing evidence around new methods and technologies [3]. There are no similar structures in the smaller professions, which have no recognised specialities, and largely lie outside the National Health System (NHS). These professions do not have the built-in governance and structures to support practice that exist in large, multidisciplinary centres such as a hospitals or primary care general practice organisations. Thus, the uptake and assurance of CPD could be seen to have a more important role in the smaller professions such as osteopathy and chiropractic for providing supporting high standards of appropriate care and engagement. The professional similarity, alongside alignment in regulatory structure, make the disciplines suitable for to study together.

Health care is changing rapidly, with advances in technology, continually updated guidelines for diagnosis, therapeutic interventions, and patient interactions, including increasing co-development of treatment plans by caregivers and recipients. Thus, continuing professional development (CPD)/continuing education is integral to health care professions. CPD may improve clinical outcomes and enhance professional confidence and satisfaction [4] [5] [6]. There is also evidence that clinicians who have been in practice longest tend to deviate most from evidence-based care [7]. Therefore, CPD is required for health professions globally to maintain high standards of care for patients and to gain confidence and trust in the regulated individuals who are part of the profession [8].

Chiropractic and osteopathy have been registered professions in the UK for only about 30 years because of the Chiropractors Act of 1994 [9] and the Osteopaths Act of 1993 [10]. Before this, no CPD was legally required, although voluntary self-regulatory professional organisations such as the General Council and Register of Osteopaths and the British Chiropractic Association performed some regulatory functions related to CPD. In the short time since registration in the UK, CPD has changed for both professions. In osteopathy, a 3-year cycle has been brought in, with an emphasis on social learning [11] with some prescribed content. In chiropractic, recent years have seen a shift towards reflective learning, with a proportion of prescribed topics [12]. In other professions, CPD has also changed over this interval, from lecture-format "lunchtime sessions", to examples of full revalidation, essentially to demonstrate ongoing competence [13].

UK chiropractic and osteopathic CPD frameworks remain comparatively structured, with UK chiropractors required to complete 30 hours annually, at least 15 involving learning with others, under a General Chiropractic Council system that emphasises reflective practice and focused reflection [14]. UK osteopaths complete 90 h over a three-year cycle, including mandatory peer discussion and activities in communication and consent, guided by the General Osteopathic Council's structured CPD scheme [15]. In contrast, the United States employs a highly variable state-by-state CE system; for example, Alaska requires 32 h biennially with mandated CE in ethics, CPR, documentation, and radiographic safety, whereas California mandates 24 biennial hours with specific requirements in ethics, examination procedures, and chiropractic techniques [16]. Canada also regulates chiropractic provincially, with jurisdictions such as British Columbia requiring 40 h every two years, including structured diagnostic-imaging training, competency assessments, and individualised learning plans [17]. Across Europe, CPD for chiropractors is supported through the European Chiropractors' Union, which recognises ECU-approved CPD courses across 22 countries, promoting mobility and consistent standards in professional development [18]. Osteopathic regulation in Europe varies substantially by nation, but harmonisation initiatives—such as the European Standard for Osteopathic Healthcare Provision (EN16686) and policy efforts led by Osteopathy Europe—aim to unify expectations for training, practice, and CPD across regulated and non-regulated jurisdictions [19]. Overall, while the UK maintains a highly structured, reflective, peer-engaged CPD culture, North American and European systems often emphasise compliance-focused, hour-based models, with Europe increasingly moving toward cross-border standardisation for chiropractic and osteopathic CPD.

Previous studies of CPD have focused on practitioners [13] [6] [20] [21] [22] [23] [5] [24], with few exceptions in which policymakers/regulators were included in a list of stakeholders [25] [26]. There is a gap in knowledge concerning the views and imperatives of regulators. It is arguable that the most influential stakeholders regarding CPD are those that work for the regulators, either full-time, or on a part-time basis. They are a mix of practitioners, educators, and those from other regulated professions as well as people who have made a career in regulation without having a clinical background. These people, with their broad range of backgrounds and life experiences can offer insights into CPD that may be useful in helping determine future directions, with the ultimate goal of improving clinical outcomes for patients as well as professional fulfilment for practitioners. Therefore, this novel study aimed to obtain the perspectives of people who work at the GCC and GOsC and who have a responsibility related to CPD to answer a broad research question: How has the design, implementation, and evolution of CPD systems in chiropractic and osteopathy reflected regulatory priorities, practitioner adherence, and quality assurance over time?

2. Methods

2.1. Design and research approach

Braun and Clarke's Reflexive Thematic Analysis Reporting Guidelines have been used to inform the structure and content of this report [27].

We chose semi-structured interviews as the method for data collection because they provided the opportunity to explore detailed accounts of participants' experiences with the concepts of CPD to try to draw out the experiences and perceptions of each participant [28]. Interview prompts were sense-checked with a practising chiropractor.

We adopted a constructivist stance, positioning this research within "Big Q″ qualitative research paradigm (Braun & Clarke, 2020). This approach recognises that knowledge is co-constructed through interaction between researchers and participants, with meaning understood as contextually situated and researcher interpretation as an integral part of knowledge making [29,30]. We adopted a reflexive thematic analytic approach, which has been identified as a useful method when examining under-researched areas [19] and is used to "identify patterns within and across data in relation to participants' lived experiences, views and perspectives, and behaviour and practices" [20] [18]. We followed Braun and Clarke's approach [31] [30] [29], recognising that thematic analysis represents a family of methods with different philosophical underpinnings. Reflexive thematic analysis specifically aligns with our constructivist stance and acknowledges the active role of researchers in theme construction. Unlike coding reliability or codebook approaches to thematic analysis, reflexive thematic analysis positions researcher subjectivity and positionality as a resource for generating insights rather than a threat to validity. This approach was appropriate given the paucity of research about CPD from regulatory perspectives, allowing us to explore this under-researched area through an interpretative lens that values the co-construction of meaning between researchers and participants. This positioning acknowledges that our analysis represents our interpretation of participants' experiences, shaped by our theoretical assumptions, professional backgrounds, and analytical choices. The co-creation of knowledge, in this case, was the result of the types of

questions asked and the exploration of follow-up question, in addition to participants' responses and the way the authors interpreted those answers in the analysis process.

2.2. Participant selection and recruitment

The aim was to identify and interview people with CPD responsibilities and interest at both PSRBs. This included administrative officers, those with strategic positions, or committee members whose remit included CPD issues, such as those with roles on education committees. This purposive sampling was justified because this group comprised the "high information" participants who held the information and lived experience that we would need to answer our research question. Thus, our criteria excluded members who, for instance, were only on professional conduct or investigating committees. We contacted the CEO/Registrars at both the GCC and GOsC, who agreed to disseminate an invitation and information about participation to staff.

Ethical approval

Approval for this study was provided by the University of Central Lancashire (now University of Lancashire) Research Ethics Committee, number HEALTH01038. Research and data sharing agreements were completed for the University of Central Lancashire and University College of Osteopathy which has merged with Health Sciences University becoming the UCO School of Osteopathy.

2.3. Data collection

Data were collected using semi-structured interviews. The authors developed an interview guide with open-ended questions (Supplementary file 1). Interviews were conducted and recorded on Microsoft Teams (Microsoft, Redmond, California). Each interview lasted between 45 and 75 min. Recordings were then shared with an experienced transcriptionist using a secure folder on the UCLan server. Transcripts were spot checked for accuracy by the principal investigator. To ensure anonymity for the participants, they were given code "names", a combination of a letter, C for chiropractic and O for osteopathy, and number (random), e.g. C3 works with the GCC.

2.4. Researcher positionality and data analysis

The principal investigator (KJY) approached this study as a health professional (chiropractic), educator and researcher with a background favouring evidence-based practice and construing professional regulation as mechanisms for raising practice standards. This positioning influenced initial interest in regulatory perspectives on CPD and shaped analytical attention toward evidence-based versus traditional approaches to professional development. The second researcher (SV) brought extensive experience in osteopathic practice, education, governance and research. He too favours evidence-based practice and considers regulation as a driver of enhanced practice. Our shared interest in professional development within manual therapy professions created both insider knowledge and potential analytical blind spots that we addressed through reflexive practices.

With reflexive thematic analysis, data analysis begins during data collection, and the interviews were conducted in a deductive/inductive hybrid approach. The perspectives of the researchers influenced the themes that would be developed. The researchers attempted to be open to the ideas expressed as meant by the participants, but this is never fully achievable. However, the approach allowed for in-depth exploration of participants' perceptions while providing enough flexibility to investigate further details and seek clarifications [32].

Throughout analysis, we maintained reflexive awareness of how our professional backgrounds, theoretical positions, and assumptions about effective CPD might influence our interpretation of participants' accounts. Reflexive meetings, correspondence and notes documented these reflections, including initial reactions to data, evolving interpretations, and recognition of how our evidence-based orientation might emphasise certain participant perspectives over others. The principal investigator maintained a detailed reflexive diary throughout the analytical process, documenting initial reactions to interviews, evolving interpretations, and recognition of how personal and professional positioning influenced analytical choices. Diary entries were made after each interview, during coding sessions, and following research team discussions. This reflexivity included questioning why certain codes seemed significant, examining assumptions about effective CPD, and considering how our evidence-based orientations might influence theme development.

Coding was open and organic, and used semantic rather than latent meanings of words and phrases. Within the constructivist framework, we used a "communities of practice" lens, in which learning is a process of social participation. Brown et al. noted that "activity and situations are integral to learning and cognition" [33]. Thus, we remained aware of the influence of practice and its difference to most of the environments that CPD learning opportunities are offered in, as well as the relationship of the PSRBs to practitioners.

Themes were the final "outcome" of data coding and iterative theme development [30]. NVivo 12 qualitative data analysis software (Lumivero, Denver, Colorado) was used to assist organisation with theme organisation and storage. One author (KJY) coded the data manually (i.e. the "autocoding" function in NVIVO was not used). A second author (SV) considered the codes at different stages for interpretative differences and confirmed or offered changes. Agreement was reached through reflective discussion. Codes were developed into themes using an iterative process. Thus, themes were developed through our interpretation of participants' responses and reflect our positionality. Themes did not emerge, as though they were pre-existing; theme development was an active process [30].

Results were organised by themes (patterns of shared meaning, united by a central concept or idea [34]) which we identified across the various interview topics, rather than within the topics. The results were then reported in a summary table as well as narratively, with supporting quotes from participants for themes and subthemes.

The data were then reported with direct quotes from participants to support them. See Table 1 for a synopsis of implementation of Braun and Clarke's six phases of implementation of reflexive thematic analysis in this project.

Table 1
Synopsis of implementation of Braun and Clarke's six phases of implementation of reflexive thematic analysis in this project.

Phase	How implemented in the paper
1. Familiarisation with the data	Interviews were transcribed, transcripts spot-checked, and the principal investigator kept reflexive diary notes after each interview.
2. Generating initial codes	Open, manual coding was performed in NVivo 12 by the principal investigator without autocoding, producing iterative codes.
3. Searching for themes	Codes were collated and iteratively grouped into candidate themes documented in a summary table and Fig. 1.
4. Reviewing themes	Themes were refined through reflective team meetings and compared back to the full dataset for coherence.
5. Defining and naming themes	Each theme was defined and named with subthemes and supporting participant quotations.
6. Producing the report	The analytic narrative integrated theme descriptions, illustrative quotes, reflexive interpretation, and linkage to regulatory and CPD literature.

3. Results

The principal investigator (KJY) conducted 10 interviews, GCC staff (n = 6) and GOsC staff (n = 4), between 20 July 2023 and 04 August 2023. We interviewed all who responded to the invitation. The responses were generally complex and nuanced, reflecting participants' deep immersion and consideration of the issues involved with CPD.

We developed two major themes and each had subthemes as illustrated in Fig. 1. The themes presented below represent patterns of shared meaning constructed through our interpretative engagement with participants' accounts. These themes are our analytical interpretation of underlying meanings, assumptions, and experiences that connected across participant accounts. Each theme captures a central organising concept that unified related codes and represents our understanding of how participants made sense of CPD within regulatory contexts.

3.1. Theme 1: the value the regulator provides with CPD monitoring

The first theme concerned the value that participants attributed to the role of the PSRB in terms of assuring registrants adhered to CPD expectations and how this impacted the public. Responses in this theme were divided into two subthemes, the value to public safety and the value to public reassurance.

3.1.1. Public safety

Ensuring the safety of the public is one of the main functions of professional regulation [35]. Staff at the regulatory bodies thought that registrants' CPD delivers some level of public safety and has an important role in the regulatory function ensuring public safety. This was seen both as an enhancing positive role as well as derogation of duty if absent.

> *"For me the GCC is all about protecting the patient … and part of that means maintaining their [registrants'] current knowledge base."* (C3)

> *"if it isn't done then that overriding mission about patient safety is compromised umm or potentially compromised."* (C6)

Solo practice is common in both chiropractic and osteopathy and was raised as an issue emphasising the importance of CPD in helping ensure public safety, and in particular, the value of group CPD activities.

> *"It's kind of encouraging, or forcing osteopaths to come out of those siloes and get into you know groups that they feel safer in and so because they feel safe in that group they are going to share things that have either happened in practice or seek advice from somebody."* (O4)

The use of fitness to practice data, based on the types of complaints

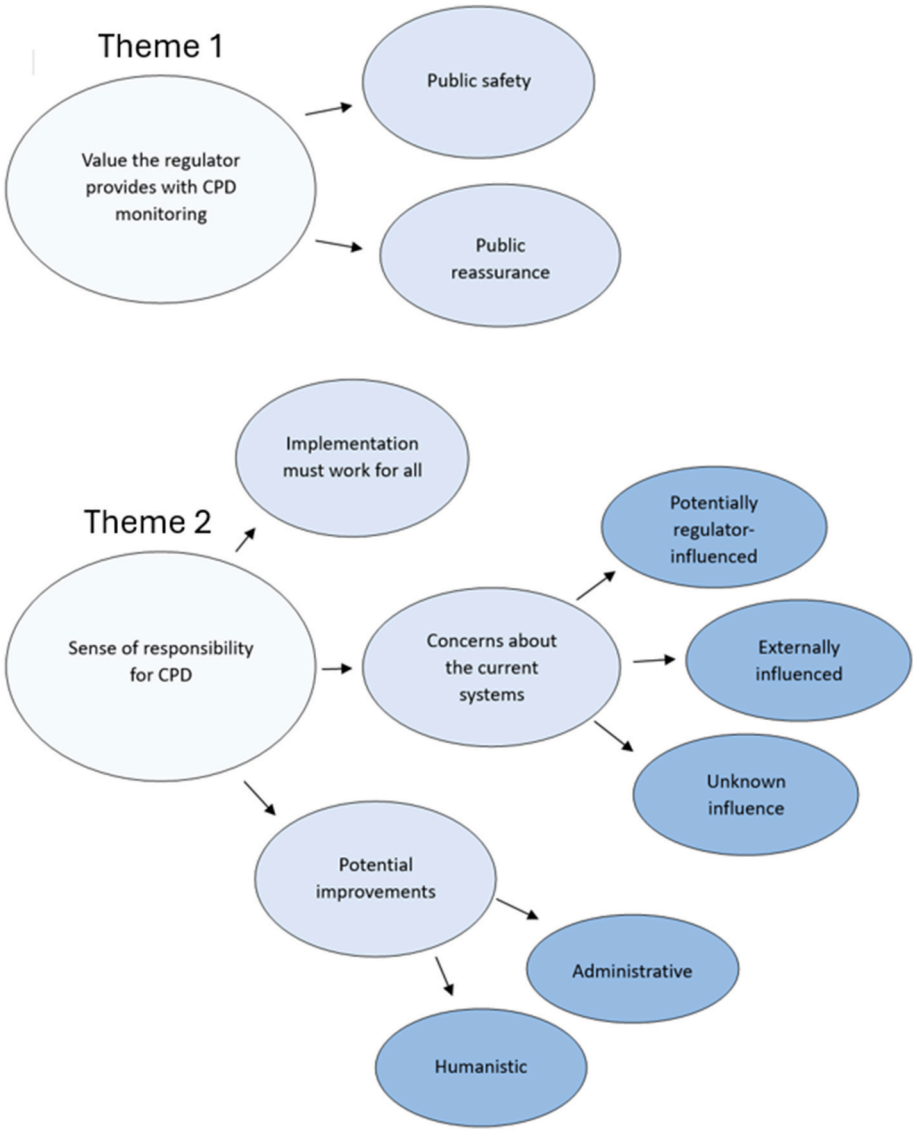


Fig. 1. Themes and subthemes from interviews of staff at the GCC and GOsC on CPD.

brought to the PSRB, drives policy decisions on content and topics that should be included in CPD cycles to help improve public safety.

> *"What we then did was kind of go out and meet osteopaths and say, look, these are the issues that are coming up in fitness to practice. We know there are issues, here's how we are trying to address them through the CPD scheme and here's examples of what you could do, so we took a very kind of linear approach of problems, solutions, here's what you can do."* (O3)

3.1.2. Public reassurance

A separate but related idea to ensuring public safety is reassuring the public that regulators are performing that function. Discussions of this function commonly reference the UK court case Bolton v Law Society [36] which affirmed that public confidence in a profession is an overriding concern for registration. This was reaffirmed more recently in another case, GMC v Chandra [37]. It is not enough for the PSRB to help ensure public safety; it must be seen to be doing so. This serves the interconnected purposes of fostering public trust in individual practitioners and upholding confidence in the profession's commitment to public welfare, both of which are essential for maintaining the fiduciary relationship that enables effective healthcare delivery. Participants in our study indicated that the PSRB had a role in demonstrating to the public that practitioners were being held to a standard, and that CPD served at least part of this role.

> *"It's to show that osteopaths are compliant with the osteopathic practice standards, so that they're performing at a level that is safe, that we feel assured that you know they should be on the register."* (O3)

Being a member of a profession carries the responsibility to continue learning and that this information should be available to the public so that they can be confident that their health care practitioners is up to date, but also so that the public is aware that assurance and accountability processes are in place as part of statutory regulation.

> *"You've then also got the reassurance for public and patients that professionals are keeping their skills up-to-date, so when they go to see whatever profession, profession they go to see for their healthcare, they can have confidence that that individual is maintaining their skills at an appropriate level and that there's a check and balance in place that that's being reviewed and looked at by an organisation, in this case, GOsC for the osteopathic profession."* (O1)

3.2. Theme 2: sense of responsibility for CPD

3.2.1. Implementation must work for all

The interviews reveal a tension in CPD regulation: the need to create inclusive frameworks that accommodate the diverse roles and career pathways within osteopathy and chiropractic professions. PSRBs face the challenge of developing CPD requirements that serve not only traditional clinical practitioners but also academics, researchers, educators, and those in policy or leadership roles. Suggesting that truly equitable CPD systems may require more fundamental recognition of different professional pathways, potentially through register annotations or specialised CPD tracks that legitimise the diverse contributions registrants make to their professions beyond or in addition to direct patient care.

> *"Not all chiropractors are seeing patients. If you're in academia umm on the education side or the research side, umm, you are umm / you are developing / you're developing yourself within the umm I suppose the definition, as it were, of being a registrant, so that's clinical practice, education, research, policy and leadership and that sort of thing, umm, then your CPD is umm you know developing you in line with that pathway within the profession, which either directly, or indirectly, is still benefiting the patient and the public."* (C2)

The GOsC has attempted to address this through broad frameworks, with one senior official explaining: *"we are trying to come up with a broad enough framework that everybody can fit within that but they can still have that freedom to move about and focus CPD on areas that are of a particular interest to those individuals within the context of the practice that they work within"* (O1)

Further tensions were present and reflected the understanding that chiropractic and osteopathy encompassed practitioners that approached manual therapy using a wide variety of approaches, from the mechanistic, traditional, and vitalistic to revisionist and evidence based. This was reflected in a number of responses that indicated a deference to the idea that autonomous professionals should be trusted to decide for themselves what type of CPD will best suit their approach but at the same time recognising the challenges of regulating such a broad scope and variety of practice.

> *"What might be relevant might be slightly different from a chiropractor working in a large practice and it might be slightly different from a sole practitioner and it might be slightly different from a vitalistic chiropractor and it might be slightly different from one at the far end of the scientific thing, so I think the segmentation of what is CPD is quite difficult, and then for a regulator, when the thing comes in, how do you decide whether what they've done is relevant to their practice. I have no idea."* (C4)

3.2.2. Concerns about the current systems

Respondents expressed significant concerns about CPD as currently implemented, reflecting challenges that emerge from different sources of influence within the regulatory landscape. These concerns reveal systemic issues that impact the effectiveness of CPD in protecting the public and supporting professional development.

3.2.2.1. Concerns - Potentially regulator influenced. Multiple concerns were expressed that could potentially be addressed through regulatory action or policy changes. A fundamental issue identified was widespread misunderstanding of the PSRB's role among registrants.

> *"I spent a lot of time explaining to osteopaths that all health professionals have to do this, it is a part of being registered in the modern day world and that our priority is not to be a professional body, we're a regulatory body, and often they confuse the two, so it was very much about umm trying to explain the why, trying to say this is essential, what our role is and also trying to convey some of the benefits to recording and reflecting on their umm uhh on their CPD activity."* (O3)

Quality control of CPD offerings represented another significant concern within regulatory influence.

> *"There isn't umm a level of accreditation that needs to happen through either the Osteopathic Council or the Chiropractic Council."* (O1)

> *"I've been to CPD uhh stuff which has basically involved people sitting round … a table in an Indian restaurant having and chat and we chat about all sorts of things, you know, how many new patients you've got, you know, how do you sack this particular receptionist, you know, what do you pay a masseur, you know, all that stuff, which is great, it's really interesting, it's fantastic to do, but is that really you know is that protecting the patient or is that yeah / so anyway, there we go. So quality is an issue."* (C3)

> *"My opinion is that, as a primary care regulated health care professional, umm, I find it bizarre that there is no umm evaluation of competency beyond graduation."* (C1)

However, the challenge of establishing quality standards proved complex and highlights the difficulty of creating universally accepted standards across diverse professional perspectives.

> *"The RCC [Royal College of Chiropractors] used to do it for a while, I don't know whether they still do, they used to nominate certain types of umm CPD as worthy, umm, but then you, you know, I'm not sure they did*

that very successfully and also you're reflecting a person or a group of people's world view, you're not reflecting perhaps the entirety of the profession and who is it that says what you do is safe and who is that says it isn't." (C3)

Several participants focused on effectiveness of CPD as a concern. Effectiveness was defined to mean improved clinical outcomes. Our broader interpretation reflects outcomes relating to public safety and reassurance.

"I'd like to see what's effective. if you've found CPD's not effective, in improving patient outcomes, you've got a really good argument for saying right, well let's toss it out the window. What are we here for if we don't improve patient outcomes?" (C3)

The same participant went deeper and indicated that it would be useful to obtain information from other professions to determine what works for them:

"Let's have a look at medicine and see whether revalidation has made any difference to them, umm, to their patient outcomes." (C3)

Similarly, some expressed doubts about how well the current CPD system improves the realities of practice:

"I'm not sure that the way that we regulate enables regulators to measure the outcomes, so we only measure the inputs usually … the identification of the need and then the learning and then the reflection, then the recording of it, it doesn't necessarily feed through necessarily into the way people practice." (C4)

Trust between PSRBs and registrants presented ongoing challenges.

"There's an element of fear and worry in there, umm, part of that may be just because you know we are the regulator and we're effectively the people that can take somebody's licence away." (O1)

"To see a lot of these individual practitioners come into a Teams call, you could see facial expressions, reluctance, frustration, fear and then meeting us as staff members from GOsC because they saw us as this faceless, unfriendly uhh organisation that was out to get them and then / and feeling often overwhelmed by the language that we used and find it bureaucratic when we talked about the CPD scheme, which then heightened fear and mistrust." (O3)

Improved communication could help mitigate mistrust and there are opportunities for improved regulatory communication and engagement.

"It may be that we need to ensure that people understand that it's not a big stick to hit them with, it is a regulatory role to ensure lifetime competence and we're here to help, sort of thing, rather than we just want to tick off your hours and make sure that your CPD return looks alright." (C4)

Our analysis proposes a fundamental disconnect between regulatory intentions for CPD and professional understanding of its purpose, reflecting deeper questions about professional maturity and responsibility. Respondents identified misunderstandings among registrants about what CPD should achieve, with many practitioners viewing it through a narrow technical lens rather than understanding its broader professional development role. This misunderstanding leads to a reductive approach that treats CPD as either a bureaucratic obstacle to overcome or a simple skills-update exercise, rather than recognising it as integral to ongoing professional competence and public protection.

The perception is that many practitioners have failed to internalise the responsibilities that accompany professional registration, instead adopting a naive, compliance-focused mindset that prioritises meeting minimum requirements over genuine development. This attitude transforms CPD from a meaningful engagement with professional growth into a "tick-box exercise" where the goal becomes demonstrating completion rather than achieving learning outcomes. The regulatory challenge lies not just in designing effective CPD systems, but in fostering professional cultures that embrace lifelong reflective learning as fundamental to healthcare practice rather than as an external imposition to be minimised or circumvented.

"If someone's perception is that you know the regulator is expecting them to be able to manipulate better after five years than two years, or 10 years than five years, or not, yeah, it's not about that, it's about kind of bigger conceptual things and professionalism." (O2)

"I do feel / and the difficulty is, with students here, they see it as a tick box exercise and it's very difficult to inspire them to want to develop themselves when they're just viewing it as, well, okay, so I've got to do 15 hours with other people and read some stuff online and tick those boxes and you know essentially what they're getting from all of this is how to write a reflective cycle, so they go away and they can write a reflective cycle, to tick a box." (C2)

3.2.2.2. Concerns - Externally influenced. The analysis reveals significant external constraints that fundamentally limit PSRBs' ability to implement optimal CPD systems, creating a regulatory environment burdened by limitations rather than strategic choice. These constraints operate at multiple levels: legislative, economic, and systemic to create regulatory limitations that force compromises which may impact public protection.

Constraint exists from outdated legislative frameworks that have failed to evolve with changing professional and healthcare contexts. Regulatory bodies find themselves enmeshed with statutory structures designed decades ago, unable to adapt their approaches to contemporary challenges or evidence about effective professional development. This legislative stagnation creates and maintains regulatory systems based on historical context inhibiting adaptive strategic design, with PSRBs forced to work within constraints that may actively constrain the evolution of their public protection activity.

The rigidity of these frameworks extends beyond simple procedural limitations to questions of regulatory authority and scope. PSRBs are prevented from implementing innovations that could improve CPD effectiveness, instead remaining bound to approaches that may have made sense in different times but lack relevance to current professional development needs.

"I think we've been reliant on the CPD umm roles within the Act for a very, very long time without any change, without any real thought given to it." (C2)

"We can't adapt the processes to deal with the market within which we're working and I think that's an impossible position for a regulator. To not be able to do anything to encourage the market to protect the public better is a bizarre situation but that's the way the Department of Health has left us, so we might have a completely different approach to CPD, if we had more freedom to think about it, but at the moment, we don't have that freedom." (C4)

A critical external constraint emerges from the unregulated nature of CPD provision, where market dynamics operate independently of quality standards or public protection priorities. PSRBs find themselves observing a CPD marketplace that may prioritise commercial success over educational effectiveness, with no mechanism in place to influence or control the quality of offerings available to their registrants. This creates a disconnect between regulatory responsibility for ensuring competent practice and regulatory authority to influence the educational mechanisms supposedly supporting that competence.

The absence of accreditation systems reflects legislative limitations, limiting quality assurance mechanisms available to the PSRBs. PSRBs recognise the problem but lack the statutory authority to address it effectively, creating a system where public protection depends on market forces and self-declarations of CPD activity that may not prioritise public interest.

"I think what's interesting within the osteopathic profession and this is outside of our sort of scope as an organisation in terms of our sort of legislative remit*, umm, is the quality of CPD good enough that individuals undertake and it's / and because there's no uhh sort of accreditation process, there's no accreditation of CPD courses."* (O1)

The small scale of chiropractic and osteopathy professions creates regulatory challenges that differ fundamentally from those faced by mainstream larger healthcare PSRBs. Resource limitations arise from small professional populations generating limited funding through registration fees which appear to registrants as disproportionately high. This impacts the GoSC and GCC that operate with minimal staff and budgets while needing to fulfil responsibilities comparable to those of much larger PSRBs.

The positioning of these professions outside mainstream healthcare governance compounds resource challenges by limiting access to broader clinical governance infrastructure available to NHS-based professions. This forces smaller PSRBs to develop comprehensive systems independently, often duplicating functions that might be shared or supported within larger healthcare systems.

"I think regulators would love to say, right, okay, well we're going to nominate what is approved CPD, but they just don't have the manpower. They don't have the resources to do that." (C3)

"It's interesting with the GCC because it's very small and it has umm / it doesn't sit in a vast kind of universe of other clinical governance organisations like the NHS does, uhh, our role in CPD is probably a little bit more hands-on than you might find at some other healthcare regulators because there's not a lot else out there to assist with it." (C6)

3.2.2.3. Concerns - Unknown influence. Participants acknowledged a gap in understanding as to why practitioners voluntarily choose to leave statutory registers rather than comply with CPD requirements. This phenomenon challenges core assumptions about the value and necessity of professional regulation for some yet remains poorly understood despite its potential implications for public protection which go beyond adherence to CPD expectations.

The existence of practitioners who continue to provide services outside regulatory frameworks raises questions about the regulatory value proposition to the small proportion of practitioners who elect to deregister and lose their title and status. Without understanding the motivations behind voluntary deregistration, PSRBs cannot determine whether their systems are appropriately calibrated, whether they create unnecessary barriers to competent practice, or whether they fail to demonstrate sufficient value to justify adherence to CPD expectations and regulatory costs. This knowledge deficit represents a threat to regulatory effectiveness and public confidence in professional oversight.

"We don't understand why people don't do their CPD and come off the register." C2

3.2.2.4. Potential improvements – administrative. Several administrative approaches could fundamentally transform CPD effectiveness through enhanced accountability mechanisms, more robust competence assurance, and structural reforms to address weaknesses in current frameworks.

A comprehensive solution is through the concept of revalidation, which would shift regulatory focus from process compliance to demonstrable competence through a comprehensive clinical examination process. This approach addresses stakeholder accountability by creating systematic mechanisms to prove ongoing professional capability rather than simply documenting educational activities. The revalidation model recognises that public protection requires evidence of maintained competence over time, not just evidence of educational participation.

This approach would transform the relationship between PSRBs and multiple stakeholder groups insurers, professional associations, other healthcare professionals, and importantly, the public by providing tangible evidence of ongoing professional competence. The current system's emphasis on educational inputs and self-report fails to address legitimate stakeholder concerns about whether practitioners remain capable of safe, effective practice throughout their careers.

"I think we owe it to a lot of stakeholders, our insurers, to the public, public first, umm, our insurance, to our associations, to other health care professionals, to the stakeholders in the profession, or in care, as a whole, I think we owe it to all of them to demonstrate our competence over time … I think I could easily argue for revalidation of the profession." (C1)

A solution that has been in part introduced involves clinical or related peer review that would bridge the gap between CPD completion and practice quality. This approach would build on discussive peer review and peer review of documented CPD to create direct observation and feedback mechanisms, transforming regulatory oversight from paper-based adherence exercises into practice-based quality assurance. The model would provide both evaluation of current CPD effectiveness and benchmarks for future learning needs, creating a continuous improvement cycle based on actual practice observation rather than self-reported educational activities.

This solution addresses the fundamental measurement problem in current CPD systems by creating stronger independent assessment of practice quality that could be compared with practitioners' self-declared learning outcomes and areas of development. The approach would provide the regulatory bodies with triangulated evidence about whether CPD investments translate into practice improvements, while offering practitioners meaningful feedback about their professional development needs.

"I think if you can find some academic chiropractors who actually practice as well, inspections would be really useful, physical inspection. I think it's the only way that you're going to get into what's going on, so for me, it is the same, it is this umm / you know / instead of a GP trainee it's a CPD evaluator. GCC could appoint someone, I don't know, call it 50,000 a year, send them into 100 practices, get them to write up what they see and measure it against what people's CPD returns say. Osteopaths could do the same. Wouldn't be difficult. Gives you a benchmark to start. Don't necessarily have to you know take it through disciplinary or anything else like that, but it gives you a benchmark to start, but through which you can then define next year's learning outcomes." (C4)

Current legislative frameworks need further exploration to test opportunities for some regulatory enhancement through direct educational provision. This represents an opportunity where PSRBs could ensure CPD quality while maintaining professional autonomy in learning choices. By utilising existing statutory powers, regulatory bodies could establish hard or soft quality standards and educational frameworks that address current market concerns in CPD provision.

This approach would allow PSRBs to demonstrate leadership in professional development while creating mechanisms to monitor and ensure educational effectiveness. Rather than remaining passive observers of educational markets that may not prioritise public protection, PSRBs could become active participants in ensuring that post-qualification education meets both professional development needs and public protection requirements.

"The Education Committee's powers to provide or arrange the provision of educational training … have never / the regulators never use that provision or that ability, so I think CPD could do more, or we need another functionality to be able to ensure or monitor or think about ongoing post graduate educational training or standards of proficiency or monitoring." (C1)

A fundamental structural issue emerges regarding the "flat" nature of career progression within both professions, which significantly impacts

professional engagement with ongoing development. Unlike other healthcare professions that offer clear advancement pathways with associated recognition and remuneration, chiropractic and osteopathy present career plateaus immediately upon qualification. This structural limitation creates perverse incentives where professional development becomes disconnected from career advancement, potentially reducing motivation for meaningful CPD engagement. There is a need for preceptor frameworks to enhance the transition from education and preregistration into practice and career frameworks to promote and develop osteopathic and chiropractic practice.

The absence of recognised specialisation pathways and limited opportunities for advanced practice roles means that CPD becomes more about maintenance than progression, contributing to adherence-focused attitudes rather than growth-oriented professional cultures. Reform of professional career structures could transform CPD from a regulatory burden into a pathway for professional advancement, creating positive incentives for ongoing development that align individual career aspirations with public protection goals.

> *"Chiropractic is a flat structure, in that once you've qualified as a chiropractor, that's it, you know, there isn't any incentive / once you / when you qualify as a physio you're a physio, then you've got particular areas that you can practice in, then you can become a first contact practitioner physio or an advanced clinical practitioner, then you can have consultant level and you've got a hierarchy and you can build your career and you can become a consultant MSK physio with prescribing rights and referral rights, you know, and everything else. But a chiropractor is just a chiropractor."* (C2)

3.2.2.5. Potential improvements - humanistic. The analysis identified significant opportunities to enhance CPD effectiveness through relationship focused interventions that address fundamental trust deficits between PSRBs and registrants. These humanistic approaches recognise that regulatory effectiveness depends not only on administrative systems but also on the quality of relationships between regulatory bodies and the professionals they oversee.

There are transformative opportunities through direct contact between regulatory staff and registrants. Current mistrust and fear appear to stem largely from the absence of human connection, with the perception that practitioners view regulatory bodies as faceless, punitive organisations rather than supportive professional partners. The interviews suggested that even limited direct engagement can fundamentally alter these perceptions, transforming adversarial relationships into collaborative ones.

This transformation extends beyond simple improved communication to fundamental shifts in how practitioners understand regulatory purpose and engage with regulatory requirements. When practitioners experience PSRBs as supportive professionals rather than disciplinary threats, their approach to CPD and regulatory compliance changes. The shift from adherence-based to development-based thinking represents a profound change that could enhance both professional satisfaction and public protection outcomes.

Successful relationships create positive feedback loops, where initial positive contact leads to increased willingness to seek regulatory support when facing professional challenges. This represents a fundamental shift from a system where practitioners avoid regulatory contact to one where they proactively engage with regulatory support when needed.

> *"[CPD is] not just the stick to beat them with, umm, and that it's not about pass or fail, it's about their professional development and how we see that and uhh breaking down levels of mistrust so yeah definitely, umm, I've seen that as a direct impact, providing these opportunities to engage with us from the CPD perspective."* (O3)

> *"I think individuals umm worry unnecessarily that they're doing things and suddenly the regulator's going to come down on them like a tonne of bricks and say, well, you've just wasted the last sort of 18 months, two years, you need to do it all again … It's there to support them as professionals and their work with patients really, I think, really, just to sort of ensure that they are, as far as we can tell fit for practice, and so communicating all of that in a way that's supportive and umm hopefully touches the / you know hits the right note."* (O1)

> *"They said to me, directly, until I'd met you or colleagues I would not have contacted you, [but then they] actually contacted us about challenging situations that had arisen with patients, umm, so from my perspective, those that reached out to us that we were able to engage with directly was wonderful."* (O3)

4. Discussion

This study explored for the first time the perceptions of people involved with CPD at UK chiropractic and osteopathic regulatory bodies. Our analysis revealed that whilst regulators recognised CPD's value for public protection, they faced significant constraints in implementing effective systems due to legislative inflexibility, resource limitations, and the structural characteristics of these smaller healthcare professions.

4.1. Professional development motivation and career structure

Our analysis revealed fundamental structural barriers to effective CPD engagement that distinguish smaller manual therapy professions from mainstream healthcare. The absence of formal career progression pathways in osteopathy and chiropractic contrasts sharply with contemporary physiotherapy demonstrating how structured advancement opportunities enhance professional development engagement [38] [39].

Stewart et al.'s (2020) survey of UK physiotherapists identified clear connections between career progression and CPD motivation, with participants valuing learning activities that contributed to professional advancement within established healthcare hierarchies. Our findings suggest that the "flat" career structures in osteopathy and chiropractic may fundamentally undermine such motivational mechanisms, potentially explaining participants' observations about adherence-focused rather than development-oriented practitioner attitudes.

Qualitative research on musculoskeletal first contact physiotherapists further demonstrates how clear career pathways and professional development opportunities create positive feedback loops for continuing education engagement Bassett and Jackson's [39]. The contrast with our participants' descriptions of limited progression possibilities suggests that structural reform may be necessary to enhance CPD effectiveness in the chiropractic and osteopathic professions. This limitation appears to interact with practice isolation to create intersecting challenges for professional development. Unlike physiotherapy, where more practitioners benefit from NHS clinical governance structures and systematic peer support, our analysis revealed how solo or small group practice in osteopathy and chiropractic may lead to professional isolation that may further reduce CPD engagement and effectiveness.

4.2. Quality assurance and market dynamics

Our analysis identified significant concerns about CPD quality that reflect broader challenges in unregulated educational markets. The absence of systematic quality oversight mechanisms contrasts markedly with larger healthcare professions where professional organisations provide structured quality assurance frameworks. Recent physiotherapy research suggests how organisations enable systematic needs assessment and quality oversight [40]. Zou et al.'s study of Australian physiotherapists demonstrates that organisational capacity supports targeted educational responses and quality monitoring that our analysis suggests are beyond the reach of the GCC and GOsC [40].

The quality concerns identified by our participants reflect what we

conceptualise as "market failure" in CPD provision, where commercial interests may not align with public protection priorities. This challenge appears particularly acute for smaller professions lacking resources for comprehensive oversight, creating risks that educational activities may fulfil compliance requirements without supporting genuine professional development or improved patient outcomes.

4.3. Regulatory relationships and trust building

Our analysis revealed significant trust deficits between PSRBs and practitioners that appear to stem from communication failures and role confusion rather than fundamental opposition to regulation. This finding extends existing healthcare governance literature by highlighting how smaller regulatory bodies face unique relationship challenges compared to larger, more established regulatory systems.

The transformative opportunities from direct regulator-practitioner engagement align with contemporary physiotherapy research emphasising relationship-building in professional development. Sellberg et al.'s [41] qualitative study demonstrated that trust and positive relationships were fundamental to effective professional learning, with successful educational environments characterised by collaborative engagement and mutual respect. However, our analysis suggests that the GCC and GOsC may face particular challenges in establishing such relationships due to resource constraints and limited opportunities for engagement. The role confusion between regulatory and professional body functions appeared to compound these challenges, requiring explicit communication efforts that may be less necessary in larger, more established professional contexts.

4.4. Implementation challenges and resource constraints

Our interpretative approach identified what we term "regulatory disadvantage" for smaller PSRBs, in this case the GOsC and GCC where the requirements to fulfil similar public protection responsibilities to larger professions but with significantly fewer resources and infrastructure support. This constraint creates limitations across multiple domains: quality assurance, practitioner support, communication and engagement, and outcome evaluation. Comprehensive professional development infrastructures deliver effective support and personal growth for clinicians transitioning from education to practice. Offering structured professional development programmes, including systematic mentoring and feedback mechanisms, significantly enhanced professional outcomes for new graduates in physiotherapy [42]. The resource constraints identified in our analysis appear to create tensions between regulatory aspirations and practical capabilities. Participants recognised the value of more sophisticated approaches such as practice-based evaluation, effective peer review and evaluation, and quality oversight, but acknowledged that implementing such approaches was challenging to their current capacity.

4.5. CPD effectiveness and outcome measurement

Our analysis identified significant concerns about measuring educational inputs rather than practice outcomes, reflecting broader challenges in healthcare professional development research. The disconnect between educational participation and practice improvement has been consistently documented in healthcare literature [43], but our findings suggest that the GCC and GOsC are particularly constrained in addressing this challenge. Current CPD systems may inadvertently prioritise adherence over competence, creating risks that educational activities fulfil regulatory requirements without supporting genuine professional improvement.

4.6. Legislative and structural reform needs

Dated legislative frameworks hamper regulatory innovation and effectiveness. The regulatory structures established in the 1990s appear increasingly inadequate for contemporary professional development needs, limiting regulatory responsiveness to evolving evidence about effective CPD approaches. Innovative approaches to professional development could inform regulatory evolution. Greenhalgh et al.'s study [44] of first contact physiotherapy practitioners showed how evolving professional roles require corresponding adaptation in professional development frameworks. However, our analysis suggests that smaller regulatory bodies lack the legislative flexibility and resources necessary for such adaptive responses. Meaningful improvement in CPD effectiveness may require fundamental reform of regulatory frameworks rather than incremental adjustments to existing systems.

4.7. Implications for policy and practice

Our analysis suggests several important implications for regulatory policy and professional development. Enhanced communication strategies emphasising collaborative cocreation addressing registrant perception of punitive approaches may be particularly effective given the personalised nature of relationships in smaller professional communities. The GOsC have recently prioritised the development of communication and engagement fora. The effectiveness of this recent prioritisation is yet to be evaluated. Existing consultation methods invite engagement. However, the effectiveness of such approaches is unclear in terms of registrant engagement and representative contribution. The quality assurance challenges identified in our analysis require innovative approaches that are feasible within resource constraints while maintaining public protection standards. This may necessitate collaborative approaches between regulatory bodies or merging with larger aligned PSRBs.

Our findings also suggest that addressing the flat career structures in osteopathy and chiropractic may be important to improving CPD engagement and effectiveness. This could involve developing formal specialisation pathways or advanced practice roles that connect professional development to meaningful career progression.

4.8. Future research priorities

Future research should investigate whether different forms of CPD engagement meaningfully influence practitioner behaviour, practice quality, and patient outcomes, particularly given regulatory concerns that current schemes measure inputs rather than competence or impact. A deeper examination of where responsibility for the quality of postgraduate education should sit is also warranted, including whether regulators have an obligation to assure CPD quality as part of their public protection remit and how this relates to the persistent gap between technical compliance, meaningful professional development, and career progression. Comparative policy studies could further clarify which regulatory levers, such as accreditation mechanisms, peer-review models, or broader interpretations of statutory powers, are feasible for smaller professions operating under legislative and resource constraints. Additionally, the phenomenon of voluntary deregistration requires urgent investigation, as its motivations and consequences remain poorly understood yet may signal deeper misalignments between regulatory systems and practitioner needs with implications for public protection. Finally, research exploring trust-building mechanisms, enhanced communication approaches, and supportive regulatory–practitioner relationships may help address cultural barriers to authentic CPD engagement within osteopathy and chiropractic.

5. Methodological considerations

5.1. Strengths

This study provides the first systematic exploration of regulatory perspectives on CPD in UK chiropractic and osteopathy, addressing a

significant gap in professional development literature that has predominantly focused on practitioner viewpoints [38] [41]. Our constructivist approach using reflexive thematic analysis enabled exploration of complex regulatory tensions and contradictions that might be obscured by more positivist methodologies.

The inclusion of participants from both chiropractic and osteopathic regulatory bodies enhanced credibility by demonstrating consistent concerns across similar professional contexts, suggesting broader applicability to other smaller healthcare professions. Our detailed reflexive practices, including positionality statements and ongoing reflexive journaling, enhance the trustworthiness of our interpretative approach within the UK healthcare governance context.

5.2. Limitations

Several limitations affect the interpretation and generalisability of our findings. Our sampling approach relied on CEO/Registrar invitation dissemination, creating potential selection bias as we cannot confirm comprehensive participation or representativeness of responses. The limitation to participants with explicit CPD responsibilities excluded other regulatory staff whose perspectives might provide different insights into regulatory challenges.

Data collection timing during a specific period in regulatory development may not capture ongoing evolution in regulatory thinking or emerging policy responses. Our analytical choices were inevitably shaped by our professional backgrounds in UK manual therapy professions and commitment to evidence-based practice, despite our reflexive practices to address such influences.

The UK-specific focus limits direct transferability to other national contexts, though conceptual insights about small profession challenges may be relevant in other contexts and jurisdictions. Finally, the absence of practitioner perspective triangulation limits our ability to evaluate the accuracy of regulatory perceptions or distinguish between specific regulatory concerns and broader systemic issues.

Ethical approval

Ethical approval was obtained through the University of Central Lancashire Research Ethics Committee, approval number HEALTH01038. Consent to participate was obtained from all participants.

Availability of data and materials

Anonymised datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.

Data statement

Data will not be made available because confidential information, such as names or professional positions, is present throughout the interviews.

Ethical approval

Ethical approval was obtained through the UCLan Research Ethics Committee, approval number HEALTH01038. Consent to participate was obtained from all participants.

Generative AI declaration

During the preparation of this work the author(s) used Claude in order to construct a reporting table for Braun and Clarke's guidance on quality of Reflexive Thematic Analysis. This table was then initially mapped and completed by Ai before author scrutiny and revision. After using this service, the authors reviewed and edited the content as needed and take full responsibility for the content of the publication.

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CRediT authorship contribution statement

Kenneth J. Young: Conceptualization, Data curation, Formal analysis, Funding acquisition, Investigation, Methodology, Project administration, Resources, Software, Validation, Writing – original draft, Writing – review & editing. **Steven Vogel:** Conceptualization, Formal analysis, Writing – original draft, Writing – review & editing. **Pamela Richards:** Methodology, Writing – review & editing.

Declaration of competing interest

Kenneth J Young reports financial support and administrative support were provided by University of Lancashire. Steven Vogel reports administrative support was provided by University College of Osteopathy. Pamela Richards reports administrative support was provided by University of Lancashire. Kenneth J Young reports a relationship with University of Lancashire that includes: employment and funding grants. Steven Vogel reports a relationship with University College of Osteopathy that includes: employment. Pamela Richards reports a relationship with University of Lancashire that includes: employment. Kenneth J Young reports a relationship with Victoria University that includes: employment. Steven Vogel is Editor-in-Chief for International Journal of Osteopathic Medicine. He had no involvement in the peer review of this article and had no access to information regarding its peer review. Full responsibility for the editorial process for this article was delegated to another journal editor. If there are other authors, they declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Appendix A. Supplementary data

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