CHAPTER 9

CONSOLIDATION OF THE CHIROPRACTORS' OCCUPATIONAL TERRITORY

9.1 REGISTRATION

As the Australian health care system expanded during the twentieth century, a complex organisation to ensure delivery of that care also developed.[1] On the consumer side of health care, this has included the development of workers' compensation, third-party accident and private insurance schemes and other state subsidies of payments for health care. On the delivery side, the development of the hospital system, community health care centres, training programmes in the tertiary education and hospital systems, and the State Health Commissions ensured that the product delivered was of high quality. Both aspects determined the structure of the system as a whole and defined the parameters of the territory of the various occupations working within the system.

Registration provided a rational means of assessing the competence of a practitioner to deliver services and thereby be eligible for subsidisation of fees for services rendered. Initially, registration secured an economic base by giving practitioners the legal right to sue patients for fees should they fail to pay for services rendered. As the health care system became more complex, so the benefits of state recognition became more valuable. Registration, then, gives an occupation access to a sound economic base. More importantly, it has become the entry point for occupations wishing to become a part of the state health care system.

It is clear from the discussion so far that registration of chiropractors was seen as an important turning point for the occupation. This was so for all the parties involved. Registration was the political legitimation of chiropractic which established the status of the occupation as a profession. More importantly, it gave the chiropractors a legally defined role in the Australian health care system and access to the benefits which other occupations in that system enjoyed.

The chiropractic associations saw legislation which would register their members <u>as chiropractors</u> as being important for the survival of their occupation. This legislation afforded a means by which chiropractic could be protected by the state. The chiropractors would no longer have to spend their time and energy protecting their identity from constant attack. They, and their

associations, could then direct their energies toward consolidating their occupational territory.

The two main factions of chiropractors (represented by the A.C.A. and the U.C.A.) as well as the osteopaths and naturopaths (mainly represented by A.N.T.A.) lobbied vigorously to ensure their members were registered by the various State Acts. They were particularly concerned that their associations should have some representation on the State Registration Boards. The first two of these associations had their position enhanced by the recommendations of the Webb Report. The Committee suggested that the members of the Boards be Ministerial appointments

> . . .drawn in balanced proportions from lists submitted by the major responsible professional organisations.[2]

The two associations which were considered to be "responsible" were the A.C.A. and the U.C.A.. The omission of A.N.T.A. in this context, together with the Committee's insistence that naturopaths from "sub-standard educational institutions" should be prevented from practising manipulation[3] weakened that association's position considerably since A.N.T.A. represented naturopaths as much as osteopaths.

The A.M.A., on the other hand, continued to oppose legislation which would give the chiropractors an autonomous status. By arguing for registration of practitioners as manipulative therapists, and registration boards with a

majority of medical practitioners and physiotherapists, they endeavoured to ensure that physiotherapists could be registered alongside of osteopaths and chiropractors thereby blurring any distinct identity for the latter. By using the argument that a health care occupation should have a minimum standard, measurable by training certificates, medical practitioners could have excluded chiropractors from registration. This, at least, was the fear of the chiropractors since the medical practitioners rejected all chiropractic training as inadequate.

The scope of the legislation and the constitution of the Boards which would govern entry into the occupation were seen, by all parties, to be crucial in determining the future development of the occupation. The link between the Boards and the training institutions is clear. While the Boards could not actually accredit tertiary courses, in the sense of determining which courses an institution may or may not offer, they could, and do, determine which courses provide satisfactory criteria for a person to be considered as being adequately trained and fit to be registered. In this way they act as a de facto accrediting agency, since an institution is not likely to offer a course, or if it did it would not be likely to get students to enrol, if the course is not considered adequate training for registration by a Board. The point is that while non-accredited courses can survive in a situation where there is no registration, their survival is threatened by registration.

After the Teece, Ward and particularly the Webb Reports, legislation which would register chiropractors became inevitable. Given the fact that chiropractors were servicing a substantial proportion of the Australian population, they could no longer be dismissed as fringe practitioners. There were three possible types of legislation which could have emerged. These were: (1) registration of chiropractors as physiotherapists[4], (2) registration of chiropractors and physiotherapists as manipulative therapists[5], or (3) registration of chiropractors as chiropractors. It was the last of these alternatives which the chiropractors wanted and which was eventually adopted.

Another important factor to be considered whilst examining registration is whether the proposed Act should simply protect the title of the occupation or whether it should prohibit the practice of therapies other than by registered practitioners. While the various inquiries suggested a prohibition of untrained practitioners from practising manipulation, most legislatures were wary about enforcing such a prohibition.

It is useful to begin by examining developments in Western Australia where the Chiropractic Registration Board had been active for eleven years at the time of publication of the Webb Report. The Western Australian Chiropractors Act only prohibited the non-registered person from using the title "chiropractor".[6] It did not prohibit such persons from

practising chiropractic therapy. Those who were not registered could, and do, practise in Western Australia as osteopaths or naturopaths. Some advertise as both.[7]

Between the enactment of the Chiropractors Act in 1964, and 1980 only American-trained practitioners were accepted by the Western Australian government as being adequately trained. This followed the recommendations of the Guthrie Report.[8] In the first two years of its operation, the Western Australian Chiropractic Registration Board refused one third of all applicants for registration.[9] This compares with a figure of nine per cent for the same initial period of operation of the Victorian Board where there was no "grandfather" clause.[10]

Eight Australian-trained practitioners were registered under the "grandfather" clause of the Western Australian Act.[11] No Australian-trained practitioner was registered after the eight initial "grandfathers".[12] By 1980, however, 102 chiropractors who "were trained in foreign countries" were registered.[13] Many of the latter did not even practise in Western Australia. By 1978 there were still only eight Australian-trained chiropractors practising in Western Australia. Three of these belonged to the U.C.A..[14] One U.C.A. member from Western Australia, F.Price, when giving a report to the N.S.W. branch of the U.C.A., commented:

> . . . the Chiropractic Profession in Western Australia is a closed shop, and the A.C.A. has complete control of the Board. When the A.C.A. takes over, they really take over.[15]

The Western Australian Chiropractors Act allowed for a majority of chiropractors on the Registration Board. As these were mainly A.C.A. members, the Board had a majority of "foreign-trained" chiropractors. Until 1980, the Board only accepted American-trained qualifications as providing an adequate standard for registration.[16] In that year, a degree from the International College of Chiropractic in Melbourne was proclaimed as an acceptable standard for registration.[17]

Earlier, the Board had refused to register Australian-trained chiropractors, arguing that to do so would mean lowering standards and jeopardising public health.[18] This was in spite of the Board's statement that the registration of the eight "grandfathers" did not lead to a lowering of standards. The appointment of an U.C.A. representative, a "grandfather", to the Board did not alter this stance.

The U.C.A., supported by the Labor Party, accused the government of supporting an A.C.A. monopoly of chiropractic.

> The Act allows the Chiropractors Registration Board, which is dominated by foreign trained chiropractors, to control a very lucrative closed-shop situation for those chiropractors. However, the public are the ones who are suffering because they have virtualy no choice about to whom they will go if they want to have chiropractic treatment.[19]

An unsuccessful prosecution by the Board of a U.C.A.

member, Mr. Van Der Velden,[20] reinforced the perception of unfair play. The prosecution was instigated by the A.C.A. which hired a private detective to prepare evidence that Van Der Velden was illegally using the title "chiropractor". The A.C.A. paid the costs of the investigation and prosecution. This prosecution was seen by members of the U.C.A. in the eastern States as a prosecution by the A.C.A., not by the Board.

In Western Australia, then, the A.C.A. was following a strategy of exclusion. The key factor in this strategy was control of the Western Australian Chiropractors Registration Board. By controlling the Board and by having explicit recognition of training institutions supported by the A.C.A., that association was able to prevent the proliferation of Australian-trained practitioners which was occurring in the eastern States. By the time registration was being considered in the east, both of the chiropractic camps were aware of the potential effect which both legislation and the constitution of the registration boards could have on the development of the occupation and the future of the colleges.

9.2 VICTORIA

After the Webb Report was published the first State to introduce and pass legislation to register chiropractors was Victoria where the Chiropractors and Osteopaths Act was passed in May of 1978.[21] A Physiotherapists Bill was

introduced into the parliament at the same time as this Bill.[22] Both of these Acts placed restrictions upon the use of particular titles but not the right to practise particular therapies, although the latter did restrict the use of specified physiotherapy equipment to registered physiotherapists or other exempted persons.[23] It registered the titles "physiotherapist" and "manipulative therapist"[24] while the Chiropractors and Osteopaths Act registered the titles "chiropractor" and "osteopath".[25]

Just as the chiropractors had continually expressed concern about the identity of their occupation, considering it to be an important part in the usefulness of any legislation, the Australian Physiotherapists' Association expressed concern that there was no definition of physiotherapy in the Victorian Act.[26] The government avoided making such a definition, leaving the task to the Registration Board.[27] The same strategy was followed in the case of the Chiropractors and Osteopaths Bill although, in this case, the government was forced to make an amendment to allow the registration of "grandfathers" in 1980.[28] This amendment effectively took the discretionary power, with regard to registering practitioners who did not have accredited degrees, away from the Board and replaced it by a statutory requirement.

In speaking to the Physiotherapists Bill, the Minister for Health stated:

> The major difference between the Masseurs Act and this Bill lies in the fact that the practise of manipulation of the human body will not be reserved to registered persons.[29]

Both Acts protected the titles, but not the practices. In each case those registered under one Act were exempt from the provisions of the other except with regard to the use of the titles. They therefore departed from the recommendation of the Ward Report that all practices should be restricted to registered persons. By establishing two distinct registration boards the Victorian government effectively supported the independent identity of chiropractic.

Initially, the Chiropractors and Osteopaths Bill had referred to chiropractic as a branch of manipulative therapy. However, the chiropractors lobbied successfully against this and any other reference to manipulative therapy in their Act, thereby retaining their autonomous identity.[30] The chiropractors also sought, and gained, amendments to eliminate the distinction between chiropractic and osteopathy which would have otherwise been incorporated into the Act. Even so, some members of the A.C.A. (the U.C.A. had amalgamated with the A.C.A. in Victoria by that time) considered the Act to be inadequate because there were only two chiropractors on a seven person Board. These members did not regard the osteopath on the Board as a chiropractor in spite of the fact that the amendments "produced a

definition of chiropractic common with osteopathy."[31]

Bolton, president of the N.S.W. branch of the A.C.A., described the Victorian Act as being:

> . . . basically the same as the manipulative therapy Bill proposed by the Liberal/Country Party Government of N.S.W. two and a half years ago.[32]

He claimed that the legislation compromised the identity and integrity of the chiropractic profession.

The legislation was not seen as being so devastating by the Victorians.[33] They felt they could at least live with it. Those who were the most apalled were chiropractors from other States, indicating that the inter-State tensions were still operating within the A.C.A.. Part of this tension revolved around rivalry between the States, especially between N.S.W. and Victoria, about the most suitable site for the location of the college. The N.S.W. chiropractors were concerned about the future of the International College of Chiropractic in the light of the Partridge Report which suggested that the Preston Institute of Technology, where the college was located and was seeking to establish itself, had a limited future.[34]

9.3 NEW SOUTH WALES.

The issue of adequacy of qualifications and the future of training programmes was raised again when a Chiropractic Bill was introduced into the N.S.W. parliament in December,

1978. Attempts were made by three groups, the Australian Physiotherapy Association, the A.C.A. and A.N.T.A., to have the Bill amended.

The Council of the N.S.W. branch of the Australian Physiotherapy Association placed a petition before the parliament which emphasised their

> opposition to the legal recognition of chiropractors and osteopaths in any form which would imply they are an alternative health care system.[35]

The petition, using the phrasing of the Webb Report, continued to suggest that only courses recognised by the Tertiary Education Commission should be accepted as criteria for registration, that chiropractors and osteopaths be restricted to treating musculo-skeletal conditions, that restrictions be placed upon practitioners advertising, that persons sitting on the Board have tertiary qualifications and that the minimum age for registration be raised from eighteen to twenty.

The first of these points is worthy of comment. It is noteworthy that the Federal body responsible for the funding of tertiary education, the T.E.C., is cited in the petition and not the State bodies responsible for the accreditation of the relevant courses. (These are the Victorian Institute of Colleges, which later became the Victorian Post-Secondary Education Commission, and the Higher Education Board in N.S.W..) In December, 1978, the same month as the N.S.W. legislation was placed before parliament, the Victorian

Institute of Colleges established an accreditation committee to examine a course in chiropractic proposed by the International College of Chiropractic and Preston Institute of Technology.[36] While the Preston course was accredited in March, 1980, in the early stages of the accreditation procedure it was not clear that the course would be located at Preston. The other alternative site was the Lincoln Institute of Health Sciences.[37] That Institute had also placed a proposal before the Victorian Institute of Colleges. This proposal was for a full manipulative therapy course.[38]

State accreditation, in fact, precedes funding. Responsibility for funding lies with the T.E.C.. The latter is a Commonwealth body and would have allowed a further arena in which the physiotherapists could have contested the claims of the chiropractors. On the other hand, perhaps the physiotherapists were as uncertain about the process of accreditation and funding of courses as the earlier chiropractors were. The petition by the physiotherapists, then, could be interpreted as being aimed at reinforcing the training programmes which they considered to be essential to maintain an adequate standard for manipulative therapy. This would have been at the expense of the autonomy of the chiropractic programmes and would have consolidated the claims of the physiotherapists as the source of expertise in manipulative therapy.

In the light of this, one proposal which was seriously considered by some members of the A.C.A. was to move the chiropractic course they were supporting (since there would be no state support until the programme was accredited by the appropriate State body) out of Victoria. The reasons given for this suggestion were that: (1) the recommendations of the Partridge Report made the tenure of the Preston Institute uncertain, (2) the fact that the Victorian Chiropractic and Osteopaths Board had a minority of chiropractors, (3) the "power of the medical profession in Victoria" and (4) the presence of para-medical training in the Lincoln Institute.[39] A five year course was proposed and the University of New England and Macquarie University were suggested as possible sites. Also, in October, 1981, the International College of Chiropractic was investigating the possibility of establishing an extension campus in Sydney.[40] If such a course could have been established and accredited, it would have been in direct competition with that offered by Sydney College. This was seen by the A.C.A. as a means of raising what they considered to be an inadequate minimum criterion accepted for registration -- a diploma from Sydney College.[41]

Discussions were held between the A.C.A. and U.C.A. about amalgamating the colleges. In the course of these discussions a proposal was raised whereby the Sydney College would become an extension of the International College of Chiropractic.[42] This proposal was rejected by both the

U.C.A. and the Sydney College as an American take over which would destroy the identity of Australian chiropractic.[43] By that time the Sydney College had designed a curriculum which entailed students completing a Bachelor of Science in Anatomy at a recognised university before they proceeded to a two year post-graduate Diploma at the college.[44] The lobbies of the A.C.A., at the time when the Chiropractic Bill was being considered by the N.S.W. parliament, were directed toward ensuring a minimum qualification which would be of a high standard.

The third thrust to amend the N.S.W. Act came from A.N.T.A.. A.N.T.A. supported the N.S.W. College of Osteopathy. This association was attempting to get representation for osteopaths on the Board.[45] The Minister for Health argued against any amendment which would have allowed such representation. He did so on the grounds that osteopathy was in a confused state and because the standard of training of the osteopaths was low.

The Act was passed without amendment. It provided for a Registration Board with a majority of chiropractors, set the Sydney College as the minimum standard of training and went some way toward licensing the actual practice of chiropractic. Three cognate Acts were passed at the same time. Two of these exempted chiropractors and osteopaths from the provisions of the Medical and Physiotherapists Acts. The third was an amendment to the Workers' Compensation Act to allow persons who attended a registered

chiropractor or osteopath to claim for that treatment if it came under the provisions of that Act.

9.4 SOUTH AUSTRALIA

The progress of the Chiropractors Bill in the South Australian parliament was influenced by the debates in Western Australia about the composition of the Chiropractors' Board. Concern about representation of Australian-trained practitioners was the dominant issue.[46] The issue of Board composition was even more crucial in the South Australian case because the Bill proposed to prohibit:

> manipulation of the human spinal column or its immediate articulations unless the person is a registered chiropractor, a legally qualified medical practitioner or a registered physiotherapist.[47]

Persons undertaking a bona fide training course were also exempt from this restriction.

Further, registration was to be based upon training courses specified by the Board or examinations set by the Board.[48] The Western Australian precedent made some of the Australian-trained practitioners who were, at that time, members of the U.C.A. or South Australian Chiropractors' Association fearful that any future Australian-trained practitioner would not be registered.[49] (The presence of a "grandfather" clause ensured that all full-time chiropractors then practising in South Australia would be registered.)[50] A legal dispute between two factions of the

Australian-trained practitioners made this issue even more important for those who were opposed to "American domination" of the occupation.

The South Australian legislation was based upon the recommendations of a working party of four chiropractors and a physiotherapist, together with representatives of the Department of Health and the Minister for Health. The chiropractors included representatives of all three associations and an "independent" chiropractor who was American-trained. The position of the Australian-trained practitioners was weakened when two-thirds of the members of the U.C.A., including their representative on the working party, joined the A.C.A., while 12 out of the 19 members of the South Australian Chiropractors' Association joined the U.C.A..[51]

The Chiropractic and Osteopathic College of South Australia in Adelaide which was supported by the remaining members of the U.C.A. was subject to a court challenge. Those Australian-trained practitioners who joined the A.C.A. wanted to integrate the college with the programme being offered at the International College of Chiropractic. Those who remained in the U.C.A. wanted the college to retain a strong link with the Sydney College of Chiropractic.[52] The latter feared that if the Registration Board was dominated by American-trained chiropractors, or their sympathisers, persons who graduated from the Adelaide college or the Sydney College would not be registered and would therefore

be ineligible to practise in South Australia.

The Minister for Health avoided commitment to any specific association other than giving an undertaking to consult with the associations.[53] The intra-occupational rivalry was not something which the government was keen to to take an active role in. The Minister, in fact, suggested that this rivalry was the cause of the delay in putting the legislation before parliament.[54]

The U.C.A. continued to campaign, unsuccessfully, for a greater representation on the Board. This entailed lobbies to parliamentarians, press releases and a submission by the Sydney College of Chiropractic to the South Australian Registration Board seeking acceptance of its certificates as appropriate qualifications for registration.[55] This last move was considered improper by the registrar, who was not a chiropractor. He insisted that the Board was an autonomous body.

9.5 OTHER STATES.

The Queensland parliament passed an Act to register chiropractors in 1980.[56] This Act remains the only registration legislation to include "manipulative therapy" in the title. This was done in spite of protests from both the chiropractors and the physiotherapists.[57] The Queensland Board has a majority of non-A.C.A. chiropractors, although the majority of the Board are chiropractors. It also

differs from the other States in that the Board can insist that a person undertake an examination set by the Board as well as prescribing which courses are a minimum requirement for registration. The Act also proscribes the prescription, by registered chiropractors, of drugs and medicines.

Legislation was enacted to register chiropractors in the Australian Capital Territory in 1982 and is pending in Tasmania and the Northern Territory.[58] By 1983 it can be reasonably expected that chiropractors will be registered in all Australian States and Territories. The strategies of the occupations of medicine and physiotherapy in opposing the political legitimation of chiropractors have, therefore, been unsuccessful. The opposition of these occupations to chiropractic continues. It remains to be seen whether the chiropractors can continue to retain their autonomy, especially in the training and research fields.

Registration marked the consolidation of the chiropractors' occupational identity. It also enhanced the control which the chiropractors were gaining over their occupational territory but cannot be considered as a sufficient criterion to define that territory. Other important aspects of this territory were the right to use X-rays, access to the hospital system, access to the repatriation health care system, referrals from other health care workers, access to insurance schemes and a state supported training base. The first of these factors, the right to use X-rays, affected the range of diagnostic

facilities which chiropractors could offer in their everyday clinical practice. The other factors affect the market which chiropractors hope to capture. They do this by reducing the cost of chiropractic treatment to some consumers, thereby making it a less expensive commodity on the health care market. The development of chiropractic radiology will be treated in depth before returning to the other aspects of chiropractic territory.

9.6 X-RAYS.

Restriction on the use of X-rays would have subordinated chiropractors to those occupations which became licensed to use this technology. These occupations were medicine, especially the speciality of radiology, and radiography. Radiology can be distinguished from radiography by the formal training given to practitioners of the former in diagnosis. Radiologists are usually medical practitioners who have specialised in X-ray diagnosis, although they also use radiation as a therapy, particularly for cancer. The chiropractors are beginning to encroach upon the diagnostic aspects of the field as they develop their expertise in differential diagnosis. Interestingly enough, the radiographers have been allies, rather than opponents, of chiropractic because of the conflict they have had with radiologists over issues such as registration.[59] Medical radiologists have opposed the registration of radiographers, putting them in a structurally similar

position to chiropractors, although many of the issues of this conflict are different from that between the chiropractors and medical practitioners.

The relative importance of chiropractic radiology was the subject of internal and external occupational disputes. These disputes followed a similar pattern to the conflict over registration. The American-trained chiropractors insisted that X-ray analysis was an integral aspect of the identity and practice of chiropractic. Many of the Australian-trained practitioners, on the other hand, claimed that, in most cases, X-ray analysis was unnecessary for effective and safe chiropractic treatment. They claimed that exposure to X-radiation constituted an unnecessary health risk to the patient. This reflected the naturopathic orientation of these practitioners.[60]

X-rays were first used by chiropractors in 1908.[61] B.J.Palmer introduced X-ray equipment to the Palmer School of Chiropractic only thirteen years after the discovery of their use as a diagnostic aid by Roentgen. "Spinography" was quickly introduced into the Palmer curriculum. While this step generated one of the many break-away factions of the period, the use of X-rays rapidly became an integral part of the American chiropractic curriculum. It was used by both "straight" and "mixer" practitioners in the U.S.. Even the group who broke away from B.J.Palmer because of his use of X-rays began using this technology. This group claimed to produce the first radiograph of a spine taken in

the upright position.[62] To-day, it is the practice of all chiropractors to X-ray the patient in an upright position. X-ray technology was particularly suited to chiropractic. It offered a means of precisely analysing the structure of the spinal column.

Chiropractors have argued along two lines for the right to use X-rays. First, they have maintained that an X-ray is an integral part of spinal analysis, essential to properly locate subluxations of the spine.[63] Second, they have argued that X-ray analysis allows the chiropractor the opportunity to detect any contra-indications for a chiropractic adjustment so that the patient is not put at risk. Even those chiropractors who have argued against the general use of X-rays in diagnosis have agreed that, in some instances, an X-ray could be necessary to detect conditions where an adjustment could be dangerous.

Medical practitioners at first opposed the right of chiropractors to use X-ray equipment. When that failed they attempted to limit the parts of the body which chiropractors could X-ray. Underlying the debate has been the role of training which legitimates expertise. More importantly for the argument of this thesis, the right of chiropractors to use X-ray equipment has been, and still is being, decided in the legal, as much as the political, arena.

In Australia, some of the early non-A.C.A. practitioners were also using this technology. The Blackney Chiropractic and Nature Cure Institute in Melbourne was X-raying up to 95 per cent of patients in 1933. The leading figure in this clinic, Reverend Blackney, was certainly not a "straight" chiropractor. He used:

> Chiropractic, Osteopathy, X-ray Therapy, Ultra Violet Therapy, Diathermy, Sinusoidalogy, Pneumotherapy (air cure), Hydrotherapy (water cure), Galvanism, Ionisation, Actinotherapy, Vibrotherapy.[64]

Patients were X-rayed on a regular basis in the Institute, both prior to, and during treatment. In this case the use of X-ray cannot be explained in terms of pecuniary motives. The Institute provided all treatment at no cost. The Reverend Blackney used an inheritance to cover the expenses of the clinic.

It should be noted, briefly, that therapies using electrical implements were extremely popular in the late nineteenth and early twentieth centuries. Many were used without any understanding of the full effects of the technology. Thus, X-ray is described by Blackney as a therapy, not as a means of diagnosis, as the American-trained chiropractors were uing it. Most of the electrical treatments have become a part of the therapeutic repertoire of physiotherapy, although there is now much more understanding of these technologies than earlier users had. In particular, conditions where such therapies will

aggravate, rather than alleviate, the complaint are more widely known than when these therapies were first used on a wide-spread basis. Some chiropractors also use these treatments. This is particularly so in the United States where a large proportion of the chiropractors offer physiotherapy treatments such as diathermy, ultra sound, and low volt electro-therapy.[65] Also, many American chiropractic colleges offering physiotherapy courses.

At the present time there are no data on the extent of use of electrical treatments amongst Australian chiropractors, although they are certainly used. The distributers of ultra sound, for example, display their wares at chiropractic conferences and consider the chiropractic market to be expanding. There is still some incidence of practitioners without any training or expertise attempting to use the sophisticated electronic technology. One technician reported several requests by naturopaths for equipment to be built. He claimed that these practitioners did not understand what they were doing and he refused to build the equipment.[66]

For the most part, therapies using electrical technology are controlled by occupations with certified training in the health care field. The medical profession, however, considers the use of this technology by chiropractors to be a gimmick to make more money and give the occupation a pseudo-scientific facade. It has been argued by some medical practitioners that there is no

radiological evidence for the existence of the chiropractic subluxation.[67] A more sophisticated critique of chiropractic radiology has focused upon the validity of the subluxation as an objective measure of pathological symptoms.[68] Those medical practitioners who do use manipulation take X-rays to detect pathological conditions which would indicate that manipulation would be dangerous.[69] They do not use X-rays to determine where or how to manipulate. The general trend has been for medical practitioners to reject the chiropractors' spinal analysis as vague and unscientific.

The right to use X-ray equipment was not covered by registration legislation. There was no attempt to restrict the use of X-rays to certified persons until the amendments to the Western Australian Medical Act referred to earlier. Chiropractors were not restricted from using X-ray equipment under the provisions of this Act because they were specifically exempted.[70] Later, the use of X-rays was controlled by Radioactive Substances or Health Acts. At one point there was discussion of the possibility of the Commonwealth Government taking legislative responsibility for the control of radioactive substances, but this did not eventuate. In May 1954, the National Health and Medical Research Council first drew attention to the potential dangers of radiation associated with X-ray.[71] Western Australia and Tasmania passed legislation to control radiation producing substances and technology in that same year. By 1959 most States had passed Radio Active

Substances Acts or amendments to the Health Acts which restricted the use of X-ray equipment to licensed or certified persons.

While medical radiologists were considered to be the practitioners with the greatest expertise in this area, all medical practitioners were exempted from the licensing provisions, as were dentists. Radiographers were also emerging as an occupation with sound technical expertise in this area, although their ability to diagnose or interpret X-rays was not formally acknowledged. Consequently, the authorities established to regulate X-ray licences tended to be dominated by medical practitioners, usually radiologists. These practitioners generally had little direct contact with chiropractors. They therefore tended to accept the A.M.A. attitude toward chiropractors as a taken-for-granted fact and became involved in excluding chiropractors from this area of health care.

The first significant incident affecting chiropractors' use of X-rays occurred in 1960 when the Tasmanian Minister for Health refused an application for an X-ray licence by an American-trained chiropractor, Richard Le Breton. Le Breton initially practised on a part-time basis in Tasmania, commuting from Victoria.[72] When he established the Tasmanian clinic he employed a radiographer to take and develop X-rays. The radiographer was supervised by a medical practitioner. This arrangement was terminated when objections were raised about the radiographer working for a

chiropractor. In the words of another chiropractor commenting on the episode:

> . . . from the very beginning certain bodies objected to this arrangement and the radiographer was forced to resign.[73]

When Le Breton applied for a licence himself, his application was refused on the advice of the Radiological Advisory Council which suggested that the health of his patients would be endangered.[74] Le Breton successfully appealed against the decision. The court case received wide media attention (200 column inches in the press). Following the court decision all A.C.A. members in Tasmania have obtained X-ray licences, although apparently no U.C.A. members hold licences.[75]

While the case was being heard, several other moves were made which reinforced the chiropractors' suspicion that there was a concerted political campaign being waged to eliminate chiropractic.

> The Sister who had previously been employed in the Clinic as a Radiographer was faced with a charge of misconduct by her Association -- which was ultimately dismissed; Mr. Le Breton was visited by two Detectives at the request of the Medical Council to investigate the claim that he was practising medicine without a licence -- this was also shown to be without foundation.
>
> During the hearing of the Appeal the Crown Solicitor attempted to establish evidence which might lead to a prosecution of Mr. Le Breton for practising Physiotherapy without being registered under the Physiotherapists

Registration Act.[76]

The success of the appeal and the failure of the opposition to Le Breton was seen, by the American-trained chiropractors, as being due to "the extensive training and high standards of practice demanded of the qualified chiropractor" together with the firm support of patients and the enlightened public.[77]

Another State where chiropractors had problems obtaining license to use X-ray equipment was Queensland, where the amendments to the Medical Act in 1955 made the operation of X-ray equipment to be equivalent to pretending to be a licensed medical practitioner. By equating the use of X-ray equipment with the illegal act of impersonating a licensed medical practitioner, the Queensland government discouraged American-trained chiropractors from establishing their practices in Queensland. (One chiropractor was successfully prosecuted for using the title Doctor, under another section of the amendment.[78]) The Medical Act was again amended in November of 1966, after the Chiropractic Act had failed to get passed by the Queensland parliament. This later amendment deleted the section which made the use of X-ray equipment equivalent to impersonating a medical practitioner. In 1970 the Radio Active Substances Act was amended to allow chiropractors in Queensland to obtain licences to use X-ray equipment.[79] Because of the restrictions placed, by earlier legislation, upon chiropractors using such equipment, very few

American-trained practitioners established practices in Queensland. This meant that the A.C.A. was both weak and few in numbers when legislation recognising chiropractors was eventually introduced in that State.

The opposition of the A.M.A. to the use of X-rays by chiropractors intensified during the period of government inquiries. The Association was explicitly opposed to any move to allow chiropractors the right to use X-rays. One senior medical practitioner claimed:

> This opposition stems from an informed concern to protect the public health and not from motives of self-interest.[80]

In the submission to the N.S.W. Committee of Inquiry, the A.M.A. insisted that the medical profession was concerned about the exposure of patients to X-radiation but that the chiropractors were not.[81] The Committee accepted this argument but suggested that registration would remove the danger outlined by the A.M.A. since chiropractors, once registered, would be able to refer patients to radiologists.[82]

On one point, however, the Committee was misinformed. The Report claimed that chiropractors took X-rays on a 36" by 14" plate. This was firmly refuted by Felix Bauer, Chairman of the A.C.A. Radiographic Advisory Committee.[83] At the time of the government inquiry, the X-ray licensing Committee of the N.S.W. government permitted chiropractors to take X-rays on films no larger than 14" by 17". (The

larger plate exposed patients to a greater amount of radiation than the smaller plate.) Bauer insisted that the chiropractors adhered to this regulation. He also claimed that chiropractors took substantially more care to reduce the amount of radiation to which patients were exposed than did many medical practitioners, including radiologists. He used a comparison of radiation doses from seven different practitioners including hospitals, a private radiologist, a radiographer and a chiropractor to indicate that the chiropractor tended to expose the patient to a lower radiation dose than the other practitioners for most of the cases.[84] In 1970 the A.C.A. Radiological Advisory Committee circularised A.C.A. members stressing the importance of gonadal shielding.[85] This Committee also offered advice to practising chiropractors on the technical aspect of radiography. This was done both through personal advice and seminars. These seminars were organised by the chiropractic associations and, later, by the International College of Chiropractic and the Sydney College of Chiropractic.

The chiropractors, especially those belonging to the A.C.A., would have liked to have had the authority to control chiropractors' use of X-ray equipment given to chiropractic registration Boards.[86] These practitioners saw X-ray diagnosis as being essential for a chiropractor to practise at an adequate and safe standard. They feared that placing such an important aspect of their practice under the authority of bodies which did not have chiropractic

representation and which were dominated by medical practitioners would result in the loss of this area of their practice. It would, therefore, have threatened their identity and ability to provide a satisfactory primary contact health care service.

This fear became a reality in 1979 when the Radiological Council of Western Australia refused to grant a licence to a practising chiropractor and to renew the licences of two other A.C.A. members.[87] The three appealed to the Supreme Court. This Appeal was partially successful. The appellants were granted licences to use X-rays, but they were restricted to taking X-rays of the spine and pelvic joints only. In the course of the hearing, an expert assessor, Professor W.S.Hare, was called in to give evidence. Professor Hare found the initial assessment of the Council faulty and, on remarking the examination papers of the appellants, found all but one to have passed the exam.[88] In giving evidence, he indicated that the expertise of chiropractors was limited to the area of the vertebral column, stating:

> Confining chiropractic radiography to the vertebral column is the emerging pattern in Australia.[89]

He cited instances in N.S.W., South Australia and Victoria to support this assertion. He claimed that any restriction to this part of the body would not involve any hardship to the chiropractors involved in the case. The limitation was

justified on the grounds that chiropractors lacked any detailed knowledge of pathology which would be necessary if they were to use X-rays for diagnosis in other areas besides the spine. It also conformed to the identity established by the A.C.A. in the early phase of political legitimation.

While chiropractors have encountered some difficulties in being able legally to use X-ray technology, they have not been prevented from doing so. Some medical practitioners have opposed the use of X-rays by chiropractors but the latter have been able to argue that they are competent to use the technology. The restrictions that could stem from the Western Australian limitation would not intefere with the general practice of chiropractic, although they could restrict the potential for chiropractors to expand the scope of their modality. Some concern has been expressed about the possible hampering of future research efforts because of the limitation but, as yet, there have been no cases where chiropractors have been prevented from practising because of the limitation. The decision in the Appeal also allowed for chiropractors to be granted a full licence should they be able to demonstrate their expertise. The International College of Chiropractic in Melbourne has attempted to establish a curriculum which can provide such an expertise. Apart from providing an intense study of radiology in the under-graduate chiropractic curriculum, the college has instituted a post-graduate diploma in chiropractic radiology.[90]

The legal sanction to take X-rays was crucial for the development of the chiropractic territory. It allowed the chiropractors to remain autonomous of other health care practitioners with regard to a crucial part of their practice. This was particularly so for the American-trained practitioners who generally put more stress upon X-ray diagnosis than their Australian-trained counterparts. However, it should also be noted that the S.C.C. is currently upgrading the radiological component of its curriculum.

The licensing of chiropractors to take X-rays, together with registration legislation forms the basis of the chiropractors' occupational territory. Both have been achieved in spite of the opposition of medical practitioners and in both cases political and legal processes have been crucial in the chiropractors' struggle to maintain control of their occupation.

9.7 INSURANCE.

Registration gave chiropractors a professional status and acknowledged their legitimate role in the health care system. This legal recognition gave the chiropractors an effective base from which they could argue for other benefits. These included state support for their training and research programmes, access to other areas of the health care system such as hospitals and community health centres, and state support for the consumer of the chiropractic

product. The last includes tax deductions for payments to chiropractors and the inclusion of payments for chiropractic treatment within workers' compensation, third party accident and private health insurance schemes. These benefits directly affect the consumers of chiropractic care, enabling them to use a therapy which they might otherwise be unable to afford. They also help consolidate the economic base of the practitioner, since he or she will get patients who might otherwise have difficulty in paying for the services provided.

The cognate Act to the N.S.W. Chiropractors Act, the Workers Compensation (Amendment) Act, is perhaps the clearest connection between registration and access to state benefits.[91] Registration in N.S.W. also brought changes to coverage by private health insurance companies of chiropractic treatment. In 1973 only two health insurance companies in N.S.W. recognised claims by chiropractors.[92] By June, 1980 there were 15.[93] In October of that year the last major fund, M.B.F., included cover for chiropractic treatment under its "extras" scheme. (Although M.B.F. still does not pay for X-rays taken by a chiropractor.)[94] It should be noted, however, that private insurance cover is limited to a set amount per person per year. This is mostly under $100.

The A.C.A. is currently lobbying to have insurance cover for chiropractic services increased as well as to have payments for chiropractic treatment made tax deductible.[95] Also they are trying to get cover for war veterans to receive chiropractic treatment under the Commonwealth scheme to cover the expenses of war related injuries or, in some cases, all health costs for returned veterans.[96] In both cases the legal status of the occupation is crucial to their argument, together with studies which indicate that chiropractic is both cheaper and more efficient than medical treatment.[97]

9.8 ETHICS

The political legitimation of chiropractic has been clearly tied to certification of competence. Competence has proved to be of far more importance than the acceptance of a code of ethics in this context. The latter is neither measurable nor enforceable without some sort of state sanction. To be sure, the associations have been concerned with establishing and enforcing a code of ethics. This concern was one of the arguments they used to claim that their members were fit to be registered. On the other hand, the medical argument against registration of chiropractors has emphasised the lack of ethics on the part of the chiropractors. In particular, they have stressed that the claims of chiropractors to be able to treat the whole gamut of human disease are unethical.[98] Also, the medical

associations have claimed that chiropractors use unethical business practices, such as given patients standardised, prewritten prognoses, which they claim are aimed at enticing patients to use chiropractic treatment over long periods for non-existent ailments.[99]

The chiropractic associations, however, have argued that they had been trying to enforce ethical behaviour amongst their members but the only sanction they could use was expulsion from the association. This was considered to be ineffective since it did not affect a person's practice. They maintained that registration would enable effective sanctions to be used against practitioners indulging in unethical behaviour.[100] This would particularly be the case if registration was necessary to practise, even if, by de-registration, a practitioner was merely prevented from gaining insurance benefits. Thus legislation protected the title "chiropractor", since de-registration would be sufficient legal grounds for an insurance company to refuse payment.

The associations have also stressed that chiropractic is not a "cure all". However, both the associations and most practitioners would claim that chiropractic treatment has beneficial effects for a wide range of complaints of an organic nature as well as specifically muscular-skeletal disorders.[101] The main problem in assessing the potential of chiropractic treatment is the lack of empirical and theoretical research necessary to verify the claims of

either the chiropractors or the medical opposition.

9.9 OCCUPATIONAL AUTONOMY.

The chiropractic associations, as organisations which directly represent the specific interests of the practitioners whom they represent, would appear to be the most obvious and effective structures to ensure occupational autonomy. However, their ability to do this is weakened by their obvious function of representing and protecting occupational interests. The issue of occupational interests versus the public interest has been at the centre of the debate about the political legitimation of chiropractic. The effectiveness of the chiropractors' lobbies, up to the point of registration, depended upon the consumer support for chiropractic practitioners offering chiropractic therapy. This consumer support mediated between the practitioners and their representative associations, and the state. The patient associations, for example, provided a structure which could put forward the argument that the chiropractors goal of achieving the status of an autonomous health care occupation was in the public interest. The effectiveness of the patient associations lay in the fact that they were <u>seen</u> to be independent of occupational interests.

With the advent of legislation the chiropractors gained direct access to public government through the State Registration Boards. Also, the professional associations have gained more direct access to public government because they have become the official representatives of an occupation which is recognised by public government. In other words, the political legitimation of chiropractic has meant that the occupation now has a legal identity which gives it more direct access to the decision making processes which directly affect the practice of chiropractic.

At the same time other organisations have emerged which can represent the chiropractors' occupational interests. While these organisations have close ties to the professional associations they are also concerned to establish their autonomy in regard to the associations. The most important organisations in this context, apart from the Registration Boards, are the two colleges which have been accredited by the State higher education authorities (the S.C.C. and the I.C.C.), the Australasian Council of Chiropractic Education (A.C.C.E.), and the Australian Spinal Research Foundation (A.S.R.F.).

It was political recognition of chiropractic, in the form of legislation which registered chiropractors, which established the formal channels to public government and enabled the occupation to change from being a pressure group to what Gilb has called a "private government".[102] Legislation effectively linked the adequacy of standards of

training to a certificate of training which was approved by the respective registration boards. The exception was the "grandfathers" who were registered on the grounds of their length of practice. Registration gave the chiropractors a good deal of autonomy because, although the boards set the minimum standards for registration, the chiropractors still have a good degree of control over the content of the proposed courses, as well as strong representation on the Registration Boards. Even though the chiropractors do not directly control the accreditation of the courses offered, they have designed the college curricula and have had representatives on the accrediting committees of both the H.E.B. and the V.I.C..

While the Boards are subject to control by the legislatures, they also act as advisory bodies to those legislatures. They can therefore mediate between the private associations and the public government. The fact that the Boards, with the exception of the Victorian Board, have a majority of chiropractors has helped maintain the autonomy of the occupation by establishing a clear channel between the occupation and public government. This autonomy was one of the key issues which the chiropractic associations were concerned with when they were lobbying for legislation. Even in the case of the Victorian Board, the lack of a majority of chiropractors does not appear to have had deleterious effects upon the autonomy of the chiropractors.

The relationship between the Boards and the associations is a difficult and, at times, contentious one. If they are to be effective structures to mediate between the practitioners and their associations, on the one hand, and the government, on the other, then they must be seen to be autonomous. Thus when a course is to be accepted as a criterion for registration by a Board, this must be done in terms of course standards, and not because the course is supported by a particular association.

It was with the aim of ensuring a sound minimum standard of training that the A.C.A. worked for the establishment of the Australian Council on Chiropractic Education in 1975.[103] The latter body was formed as an organisation which would be autonomous to the associations. It has as many non-chiropractors as chiropractors as members. The former have included a past dean of the medical school of Monash University, the Chairman of the Commonwealth Committee of Enquiry, who is Professor Webb, the Vice-Chancellor of Macquarie University, and Professor Dillon, a senior academic from U.N.E.. The main function of the A.C.C.E. has been to act as an accrediting body for chiropractic training courses. However, in this capacity, it has been an object of contention.

The U.C.A. has seen the A.C.C.E. as a mechanism which would ensure the domination of the chiropractic occupation is Australia by the American chiropractic associations (not just the A.C.A.). This has been the case even when the

Federal President of that association, E. Devereaux, was a member of the A.C.C.E.. The remaining college supported by the U.C.A., the Sydney College of Chiropractic, has consistently refused to recognise the A.C.C.E. or to subject its training programme to that organisation's accreditation procedures although it did apply for and receive accreditation from the Higher Education Board, the official accrediting agency of the N.S.W. government.[104] This refusal, together with allegations that the accreditation of the Sydney College was not properly conducted, has reinforced the argument by the A.C.A. that the standards of the Sydney College are not adequate.[105]

The position of the A.C.C.E. was weakened by the Webb Committee's recommendation that the Council:

> should not be recognised by Government or Registration Boards as an accrediting agency for chiropractic colleges.[106]

However, the official recognition of the Council by two Registration Boards, the unofficial recognition by one other, the acceptance by Professor Webb of a position on the Council and the participation by a member of the Council on the Victorian Institute of Colleges' committee to accredit the chiropractic course at the Preston Institute of Technology has given the Council recognition as an authoritative body.[107] As such it has worked toward maintaining the autonomy of both the training and the practice of chiropractors in Australia.

9.10 HOSPITALS.

The area where chiropractors have been having the least success has been in gaining access to the hospital system. In N.S.W. two chiropractors based in Cowra approached the nearby Boorowa and Glenfell District Hospital Boards offering to operate a regular clinic in each town, at the request of their patients, if the Boards would make available a room and X-ray facilities.[108] The Boards agreed but were overruled by the N.S.W. Health Commission.[109] More recently, a case involving a patient at the Royal Newcastle Hospital received widespread media attention. A patient, Stephen Bennet, had received spinal injuries and lapsed into a coma. Amongst other treatments, his parents sought chiropractic care for their son but the Hospital Board, with the backing of the Health Commission, refused permission for the chiropractor to undertake his therapy in the hospital.[110] Bennet now receives treatment at his home.

9.11 ANIMAL TREATMENTS.

A final potential area of conflict for the chiropractors arises out of the use of chiropractic adjustment on animals. This is an area of practice which is presently unrestricted but which impinges upon the territory of veterinarians. Thus far there does not appear to have been any conflict between the two occupations, perhaps because there are only a few chiropractors interested in the field. It is an area where the occupational boundary will

probably have to be defined through legal or political action at some time in the future.

9.12 EDUCATION AND IDENTITY.

While the chiropractors are currently establishing an occupational territory, there is still, amongst the practitioners, a great deal of concern about the identity of the occupation. Associates of the Sydney College and members of the U.C.A. are still stressing the need for an autonomous, Australian identity based upon Australian training. Because of the large proportion of the teaching staff at the I.C.C., some of the Australian-trained practitioners still hold to the naive conspiracy theory which suggests that the I.C.C. is a part of a take-over of Australian chiropractic by American chiropractors.[111] However this notion has far less support at present than it did in the past, even amongst Sydney College graduates. The clearest indication of the shift in support for this stance is the decision of many of the Australian-trained practitioners to leave the U.C.A. and join the A.C.A.. The former has lost its former status as an association which represented the majority of Australian chiropractors. The South Australian and Victorian branches of the U.C.A. merged with the A.C.A. in 1978 and a large number of members of the N.S.W. branch of the U.C.A. joined the A.C.A. in 1980. Amongst the latter were the President of that branch (and former principal of the S.C.C.) and the

State secretary.[112] The U.C.A. was revived in South Australia in 1979 but remains a minority faction. The main support for the U.C.A. now lies in N.S.W. and Queensland.

For the most part, chiropractors have lost interest in the debate betwen the Australian-trained and American-trained practitioners and are more concerned with the development of the occupation as a whole. The emergence of the I.C.C. and the upgrading of the curriculum and facilities of the S.C.C. has helped diminish the differences between the groups. Although there is still some disputes between the colleges over their relative merits, these disputes are nowhere near as bitter as those of the past. The new principal of the S.C.C. has recently attended seminars organised for practitioners by the I.C.C.. This is in marked contrast to the earlier A.C.A. stance toward the Australian-trained practitioners whem members of the A.C.A. objected to either Australian colleges or practitioners receiving the benefits of American expertise in the field.

The occupational identity of chiropractic is also being established outside the educational institutions. The strongest force in this area is an American entrepeneurial group, "Renaissance International".[113] This group has run practice management seminars in Australia since 1976. These seminars are what might be termed "motivation seminars". They aim to motivate chiropractors to sell chiropractic. The seminars use material developed by chiropractors and

medical researchers to support the philosophy of chiropractic as a therapy which enhances a person's potential. The group also sells a range of sophisticated audio-visual and printed material for chiropractors to use when they explain the purpose of chiropractic to patients in their clinic. The professed aim of the group is to bind the occupation together in terms of the patient and the occupation rather than technique, training or philosophy.

These seminars are a good example of how the ideological foundations of the chiropractors rhetoric are maintained at an everyday level. The fact that they cater for practitioners of a wide range of educational backgrounds is a clear indication that the divisive factions are losing their force within the occupation. However, it should be noted that not all chiropractors follow the Renaissance programme. Even so, the disputes between chiropractors over the suitability of this, or any other programme, are taking place within the occupation, rather than at the public or political level as they did in the past. Now that chiropractic has gained political recognition, the force of the arguments within the occupation is lost. The development of identity has become a more complex process, incorporating socialisation during the training period and a more rational debate between the practitioners than occurred in the earlier stages of the occupation.

The occupation has been identified with expertise in the use of a specific therapy which is particularly effective for treating complaints of the musculo-skeletal system. The future development of the occupation will depend upon how well the chiropractors can oppose the trend to limit their practice to this area. This will depend upon patient support, to some degree. However, the validation of chiropractic hypotheses will play an increasingly important role in the long term development of the occupation.

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CHAPTER 10

CONCLUSION

Chiropractors have been practising in Australia for close to seventy years. The changes which have occurred in the occupation during this period have been dramatic. Four principal elements have caused these changes. These are: (1) the development and upgrading of training facilities for practitioners, (2) the formation of professional associations, (3) consumer support, and (4) the obtaining of political recognition, giving the occupation a legally recognised territory. The main factor which has retarded the progress of the occupation has been the opposition of the medical profession to any form of political recognition of chiropractic. These factors, though distinct, are interrelated and cannot be considered in isolation. For example, the professional associations have played a crucial role in the upgrading of training facilities, and the opposition of the medical profession directly and indirectly influenced the strategies of the chiropractic associations with regard to seeking political legitimation.

I have used the concepts "occupational identity" and "occupational territory" as heuristic devices to clarify the different phases of the changes which the occupation has undergone. The former is concerned with the relations between chiropractic, on the one hand, and consumers of chiropractic services, other occupations and the state, on the other. These relations are external to the occupation yet, at the same time, crucial to the development of the occupation. An "occupational territory" specifically refers to the legitimation of an occupation by the state. It is dependent upon the establishment of an occupational identity.

The identity of chiropractic was crucial for two reasons: firstly, because the occupation was attempting to establish a therapy which was alien to the health care system; secondly, because it provided a basis upon which to develop a coherent and sound course of training. The chiropractors had to distinguish their practice from other unorthodox therapies, particularly naturopathy in order to establish the credentials necessary to gain the political support essential for the survival of the occupation. They also had to demonstrate that they provided a service which was not provided by other health care occupations, particularly physiotherapy. Thus, while the identity of the occupation was generated by the practitioners, its significance lay in the manner in which it influenced factors which were outside the realm of everyday practice.

The issue of standards of training is even more clearly related to the external factors which affected the development of the occupation. The adequacy of training provided a concrete measure whereby the competence of practitioners could be judged. This was necessary for the occupation to be assessed by state agencies.

Initially, the chiropractors had no means of establishing an exclusive claim of the therapy which was the basis of their occupation. It is not clear why medical practitioners did not incorporate manipulative therapy within standard medical training, or research the effectiveness of the practice with the same vigour that has been applied to some of the more orthodox medical techniques. This option was open to medicine in the early twentieth century. As it was, the failure of medical practitioners to incorporate the practice of manipulation within their occupation's therapeutic repetoire meant that the practice could be readily adopted by other individuals or groups. This provided the ground in which the nascent occupation of chiropractic could grow. It can be hypothesised that the use of manipulation by bone-setters, chiropractors and osteopaths led to a stigma being attached to this therapy by medical practitioners. Consequently researchers were wary of risking their careers on such research in spite of the encouragement of such eminent medical men as Hood, Mennell and Cyriax. Certainly the failure of the medical profession to take up both the

research and actual practice of manipulation, until recently, is an issue which requires more detailed examination.

It was in this context that the small group of chiropractors who had trained in America were determined to maintain the identity of chiropractic as an autonomous, primary-contact, health care occupation which provided a specific and effective therapy -- the chiropractic adjustment. The success of the therapy and of the A.C.A. in gaining recognition for chiropractic practitioners in Western Australia, combined with the unregulated nature of the field, meant that many persons began to identify themselves as chiropractors with little or no formal training. Because chiropractic used neither drugs nor surgery, proponents of Nature Cure and naturopathy became attracted to the the use of the therapy. Initially such practitioners used chiropractic adjustment as one of a wide range of treatments. Many adopted the practice with only a superficial training in either the therapy or the basic biological sciences now considered necessary to understand the mechanisms of healing as well as to diagnose pathologies. The lack of extensive training of many chiropractors and the unscientific explanations of disease offered by many practitioners, led most medical practitioners to consider them as quacks and charlatans. By excluding such persons from the health care system and opposing any form of political legitimation of practices

outside the influence of medicine, the associations representing medical practitioners considered themselves to be performing a public service. In effect the medical strategy of exclusion became a self-fulfilling prophecy since there was no regulation or means whereby the public could judge the adequacy of training, and many persons who could be called quacks or charlatans began to practise as chiropractors.

The history of chiropractic has been marked by a struggle to gain control over a field of health care practice in terms of their claim to a unique ability to provide a particular service. The A.C.A., for example, strove to distinguish its members from the other practitioners who were beginning to use the appellation "chiropractor". That association had two explicit goals. Firstly, it aimed to distinguish chiropractic from other therapeutic practices which were beginning to be identified as the natural therapies or, from the mid 1960s as alternative medicine. Secondly, it aimed to stress what was considered by the association and its members to be the superior training of American-trained practitioners. The first goal, the struggle to maintain a unique identity, was an attempt to gain control over a therapeutic field. The justification for this political strategy was couched in terms of a claim to a unique expertise based upon high standards of training.

Chiropractic emerged in Australia at a time when medicine was consolidating its position as the dominant occupation in the health care system. Because chiropractors learnt their skills outside medical training institutions and because they espoused an approach from healing which was radically different to that put forward by the emerging medical orthodoxy, they were placed in a structurally marginal position. As a consequence they were a small group amongst the numerous non-medical practitioners working in this country in the first part of the twentieth century. The occupation remained fragmented and marginal, with few practitioners until the 1960s.

To-day chiropractors have achieved a legitimate status in the Australian health care system. They have done this through active lobbying of both State and Federal governments (and their respective agencies), through legal challenges to decisions which would have restricted their practices, and by developing training programmes to ensure that practitioners would have qualifications which would be acceptable to the relevant state institutions. The establishment of government inquiries, for example, was a direct result of the chiropractic lobbies, together with the medical opposition to any form of political recognition of chiropractic. The Le Breton case in Tasmania illustrates the importance of legal support for the chiropractors' right to practice. Without the success of Le Breton's appeal, chiropractors in Tasmania would not have been able to

practise what they felt to be chiropractic, i.e., a therapy based upon X-ray diagnosis. The establishment of the I.C.C. in conjunction with the P.I.T., together with the upgrading of the S.C.C. curriculum were the main factors in establishing the credentials of the chiropractors' training programmes. The most important manifestations of political legitimation have been the enactment of State legislation registering chiropractors, the licensing of chiropractors to use X-rays and the development of chiropractic training within the Australian tertiary education system.

Because the accepted source of expertise on matters related to health care was the occupation of medicine, and because that occupation completely rejected any claims by chiropractors about either the effectiveness of chiropractic treatment or the adequacy of their training, the chiropractors were forced to turn to other sources of support for their claims. The first source to which the chiropractors turned was the one with which they already had established lines of communication -- the chiropractic patient. The second source was the only one which could ultimately override the sanctions imposed by medicine -- the state.

In order to win support in the political arena, the chiropractors had to first demonstrate that there was widespread support for their occupation. It was at this point that the massive increase in the number of persons practising as chiropractors, which was generated by the

proliferation of Australian colleges, was crucial. The increased number of persons identifying themselves as chiropractors led to a large number of patients identifying chiropractic as the occupation which provided the most effective service with regard to disorders of a musculo-skeletal type. The findings of the Webb Enquiry gave convincing support for the chiropractors' claim that a significant part of the community considered their occupation as a legitimate provider of a valid health care service. This was in spite of medical claims to the contrary. Of course this also indicated that, while the standards of the Australian colleges might be criticised, they were still producing practitioners who were capable of providing an effective therapy. The result of the acceptance of the Australian-trained practitioner by the government inquiries of the 1970s was that the A.C.A. moved from a strategy of exclusion, vis-a-vis the Australian-trained practitioners, to one of co-option. Where the A.C.A. was the minority association in the 1970s, it became the association representing most chiropractors in the 1980s.

The detailed examination of the history of the occupation reveals that political legitimation has been crucial to the very survival of the occupation as well as its subsequent development. The role of the state as arbiter in an occupational dispute is predicated upon two factors. First, a specific practice must be identified as

an important social issue. Second, particular occupational groups must be identified as being competent to perform the particular tasks. The mechanisms whereby chiropractic was identified in this way were the government inquiries. Various government inquiries identified spinal manipulation as an effective therapy. They also distinguished this practice from other therapies practised in conjunction with manipulation by unorthodox practitioners. Of these, naturopathy was not accepted as a therapy which was considered to be suitable for the Australian health care system.

Chiropractors were not, however, recognised as the sole source of expertise in the area of manipulative therapy. Medical practitioners and physiotherapists also were recognised as being able to undertake this type of treatment effectively. Therefore after establishing their occupational identity the next step in the legitimation of chiropractic was to secure state recognition of the occupation at least equal to the recognition given to medical practitioners and physiotherapists, i.e., as an autonomous health care occupation with its unique training programmes. The chiropractors argued for this on the grounds that they had the technical expertise necessary to ensure that public interests were protected.

The medical practitioners and physiotherapists argued that the chiropractors did not have the technical qualifications they claimed, and that medicine and physiotherapy offered suitable training programmes which could ensure that sufficient practitioners would be available to the Australian public without the necessity of endorsing chiropractic. Ultimately it was the State and Federal governments which endorsed chiropractic as an autonomous occupation by registering chiropractors, and accrediting and funding chiropractic training programmes.

By examining the process of political legitimation of chiropractic a number of conclusions can be drawn which have important implications for the sociology of occupations. First, an adequate explanation of occupational change can be gained by analysing relations between the occupation, other occupations and state agencies. In effect, social relations within the occupation itself are largely determined by the external relationships. Second, the social relations which constitute the basis for occupational change are power relations, that is, relations between occupations characterised by dominance and control, rather that harmony and co-operation guided by an ideal of service. Third, occupational change cannot be explained in terms of the "attributes" which an occupation possesses but must be explained in terms of how the "attributes" are used by an occupation to gain political recognition. Finally, the underlying assumption of the functionalist paradigm in this

field -- that the ideal of service is the basis for professionalisation -- is called into question.

Occupational power is fundamental to an adequate explanation of occupational change. It refers both to the capacity of one occupation to control or influence another occupation, and to the capacity of an occupation to control itself. Thus occupational power refers to relations between an occupation and other groups as well as relations within the occupation itself. In the subordinating, limiting and co-opting modes of domination, control and influence can operate without the direct intervention of the state. However, the authority to dominate a particular field, e.g. the authoritative position of medicine in the health care field, is ultimately determined by the state. This is generally only made manifest when medical authority is challenged by another occupation. Thus when medical practitioners were challenged publicly to justify the exclusion of chiropractors from the hospital system, the State Health Commission supported their stance. That is, the authority of medical practitioners to exclude chiropractors was legitimated by an agency of the state. Chiropractors will not gain access to the hospital system until that decision is overruled.

The authority of an occupation, or more specifically the authority of practitioners' expertise, is recognised by the legal, political and other social institutions of the state as the occupation strives to become a profession.

This recognition enables the members of the occupation to define the terrain of the occupational territory within which they operate. In this way occupational autonomy is established. This means that control of the occupation is in the hands of the members of the occupation and does not rest with either other occupations or consumers. Independent control over education, X-ray use, registration or licensing and, more recently, research has given the chiropractors the power to define the identity of the occupation and the terrain of the occupational territory. This power is effective both at the level of everyday practice and at the broader level of occupational development.

The relationship between medicine and chiropractic has been one of domination of chiropractic by medicine. An expression of this dominance is the strategy followed by the medical profession of excluding chiropractors from the legitimate health care system. This strategy made the relations of dominance and conflict clear and unambiguous. However, the relations between medicine and other health care occupations, such as nursing, optometry and physiotherapy, are also characterised by conflict and dominance although these relations are not necessarily so transparently hostile. The other modes of dominance -- subordination, limitation and co-option -- allow for conflicts to be resolved without a continued and public struggle. Generally new occupations trying to establish

their authority will have to challenge the authority of the more established occupations: chiropractors have challenged medical practitioners; radiographers have challenged radiologists; and optometrists have challenged opthalmologists. In each case, the occupational associations have attempted to establish the authority of their members as an authority which is not dependent upon medical practitioners. In other words, these occupations have been attempting to institute changes which would establish their autonomy.

The medical strategy of exclusion has relied upon the authority of medical expertise to influence the decisions of "public government", together with the support for another occupation, physiotherapy, which the medical profession felt was the most suitable occupation to perform manipulative therapy. Chiropractors have also attempted to influence the decisions of public government, in so far as these decisions have affected chiropractic. Because the chiropractors did not have the patronage of the medical profession, they were forced to seek an alternative source of legitimation. This source was the consumer of chiropractic care.

The chiropractors have used consumer legitimation to gain access to public government. Working as a pressure group, with the support of chiropractic patients, the chiropractors mounted an effective political challenge to the medical dominance of the health care system which had resulted in their exclusion from that system. The political

legitimation of chiropractic effectively consolidated the boundary of an occupational territory within which chiropractic practitioners could operate without fear of recrimination instigated by medical practitioners. Occupational power can refer to the capacity of an occupation to influence clients. Relations between the practitioner and the client have only been dealt with in so far as the support of the consumer has been recognised as having played a crucial role in the development of the occupation. I have not attempted to examine in any detail the reasons for this support. This subject would be worthy of further investigation. Apart from an examination of the general attitudes of patients toward chiropractors, the ability of chiropractors to comply with the chiropractic regime, and the perceived effectiveness of chiropractic treatment, such a study should examine the different techniques used by different chiropractors and test for the effectiveness of treatment for different types of complaints over a substantial period of time.

The occupational territory of chiropractic is still a matter for dispute and negotiation. Debates continue, both within and without the occupation, about the status of chiropractic as an occupation and the validity of its practice. It would be worthwhile, in a future study, to examine whether the chiropractors can maintain their status as an autonomous health care occupation, or whether they succumb to medical domination in one form or another.

The changes which chiropractic has undergone cannot be explained merely by discovering whether or not the occupation possesses a set of attributes. This approach, termed the attribute approach, was used by some writers, e.g. Greenwood, working within the functionalist paradigm and has been used by many sociologists to analyse occupations. The main problem with such an approach is that it is oriented toward describing whether an occupation can be described as a profession at a given point in time -- an argument which is both circular and ahistorical. It is circular because it describes an occupation as a profession because it possesses specific attributes which are, in turn, "discovered" by studying specific "professions". As such, this argument avoids analysis of the process whereby an occupation achieves these attributes, how the attributes are used in the claims for professional status and an explanation of why some occupations can use attributes to consolidate their status, while others cannot.

Other functionalist approaches to professions and professionalisation, e.g. those of Goode and Parsons, at least avoided circularity by posing certain attributes as core characteristics. These core characteristics were derived from the functionalist model of society. Technical expertise and an ideal of service were two such characteristics. These two characteristics were seen by many functionalist writers to be important elements in beneficial social change. They argued that because

professions required extensive training at a sophisticated level for their recruits and the practitioners provided services which were necessary to maintain advanced industrialised societies,professionals occupy an important position in the division of labour in those societies. This position carried with it the rewards of high status and good incomes. The problem with this argument is that it ignores the political processes which are crucial to any changes in the division of labour. Thus an explanation of occupational power comes to rest upon either the given attributes or what is defined as a "beneficial" social change. A corollary is that any such occupation puts the interest of the public (or society) before its own interests.

The analysis of chiropractic has indicated clearly that attributes, such as technical expertise or an ideal of service, are important factors in an explanation of occupational change. However, their importance lies, not merely in determining whether the occupation possesses such attributes, but in the way in which its members claim that they possess them in order to consolidate the occupation's position within the division of labour. Professional attributes can be used as guidelines for empirical investigation. They are not sufficient to explain occupational change.

If attributes are used without an account of the historical development of the occupation, they become virtually meaningless as tools for analysing occupational change. Such an analysis may give good insights into the relative position of an occupation at a given time, but it does not allow for an adequate description, let alone an explanation, of the process of professionalisation. It would be worthwhile, in a future study, to undertake a comparative historical analysis of the development of chiropractic in a number of countries. This could assist in developing a theory of occupational change which would not be restricted by the limitations of the present study by enabling an analysis of the effects of the different variables such as education, consumer support and medical oppostion in different settings. Chiropractic provides an excellent case for such a study since it is a new occupation in different stages of development in different countries. It has achieved political legitimation in Australia, Canada and the U.S., while it has failed to gain this legitimation in South Africa and Britain. In other countries, such as Japan and Singapore, chiropractic has had to compete with more traditional practitioners who practise similiar techniques. In the case of competition with traditional therapeutic practices, the comparative study would have to take into account the conflict between these therapies and "Western medicine". The advantage of using chiropractic to undertake such a study is that, because of its relatively recent emergence in different health care systems, there is

an abundance of material available.

Another problem with most functionalist accounts of the professions is that they tend to concentrate on features which are internal to an occupation. Consequently, an examination of the relations between the occupation under scrutiny and other occupations, consumers or the state, does not play a significant role in the functionalist analyses. This is in spite of functionalism's claim that it takes a holistic approach to the study of society. A historical approach, therefore, needs to incorporate an analysis of the relations between the occupation under scrutiny and other related occupations, as well as other political and social factors, if it is to provide a more adequate analysis of occupations and the process of professionalisation than the functionalist accounts. This is because an occupation does not develop in isolation but, rather, emerges within a division of labour which is, generally, well established. While the boundaries to the division of labour might, in some cases, be negotiated through some form of consensus, in the last instance the power to determine occupational boundaries rests with the state, not with characteristics which are "inherent" to a particular occupation.

The professional ideal of service, which was espoused by both medical practitioners and chiropractors throughout this struggle, masked the occupational interests which were the source of the occupational conflict. The A.M.A. and its members considered themselves to be serving the public's

interest by excluding chiropractors from political legitimation. Likewise the chiropractors, together with their representative associations, also considered that proper recognition of their occupation was in the public interest. However, the other important element in the conflict was the struggle to gain control of an occupational territory. Each protagonist recognised their opponent's occupational interests but seldom, if ever, publically admitted their own.

I would not want to claim, however, that the attributes used in functionalist accounts of the professions can be dismissed in an account of occupational change. Indeed, the formation of associations and the public acceptance of an occupational practice are two such attributes which are crucial to an understanding of the occupation under scrutiny in this thesis. What I would claim is that if the use of such attributes is to contribute to an adequate account of the dynamics of occupational change and lead to a sound explanation of such changes, then they must be firmly related to power relations and the legitimation of occupational authority within the division of labour.

If an adequate explanation of occupational change requires an examination of how the attributes are used in legitimating an occupation at the political level, then the analysis of change must take into account social processes which are external to the occupation, together with the processes which are associated with the internal development

of the occupation. Specifically, the analysis of external relations must take place at three levels: between the occupation and consumers of the occupational product; between the occupation and the state; and between the occupation and other related occupations. Inter-occupational power relations are neither given nor constant, but are determined through a resolution of conflict between distinct occupational groups. This struggle is mediated by the social and political institutions of the state. In the case of chiropractic, the relevant occupational groups have been the different chiropractic factions, together with occupations which can be grouped under the general rubric of naturopathy as well as the occupations medicine and physiotherapy. The relevant state institutions have been the legislatures with their respective investigations, State education accrediting agencies and Registration Boards for the respective occupations.

There does not necessarily have to be a consensus at all three levels for the legitimation of the occupation to occur. In the case of chiropractic, there was strong support from the consumers of the chiropractic product for political recognition of chiropractic. There was also substantial opposition, at the occupational level, from medicine and physiotherapy.

One of the main premises of the medical argument against chiropractic was that both the theory and the practice were unscientific and unproven. This argument reflected a broader postulate which maintained that the current prominent position of the medical profession, in both the health care system and the society, was due to its scientific underpinnings. The medical argument against chiropractic generalised from this postulate to claim that the right of any occupation to gain recognition as a legitimate health care occupation ought to be contingent upon the occupation's having a firm scientific foundation. What such an argument did not take into account was the uneven distribution of scientific resources. Research funding and facilities, as well as training programmes which are geared to the research enterprise, have not been made available to chiropractors until recent times. Consequently, the chiropractors have not had access to the resources to legitimate their practice at the scientific level. In fact, the original "unscientific" epistemology from which chiropractic developed tended to invite immediate dismissal rather than serious investigation. As a consequence, the medical argument against the unscientific nature of chiropractic came to be a manifestation of professional rhetoric rather than a reasoned scientific argument.

By relying upon first clinical, and then political, legitimation, the chiropractors have been able to establish an occupational territory without using scientific legitimation. Thus it is clear that scientific legitimation is not necessary for an occupation to be able to establish an occupational territory in the health care system. However, the role of scientific legitimation should not be underestimated. While chiropractic does not, at present, have a sound research base, chiropractors are trying to develop such a base. Throughout the debates on the future of the occupation, the chiropractors consistently maintained that their discipline was a science and the lack of any scientific research with which their theories could be proved resulted from their exclusion from the tertiary education sector and not from the nature of their discipline. Now that the chiropractors have gained access to the tertiary education system as well as research funding, scientific legitimation is likely to play an increasingly important role in the development of the occupation.

The other, more substantial, aspect of the medical attack on chiropractic focused on the inadequacy of the chiropractor's training programmes. The claim that chiropractors were trained inadequately is, in part, related to the issue of scientific credibility. "Adequate training" in the health care field has come to mean training in sciences such as biology, chemistry and physiology as well

as in techniques relevant to the practice of the occupation and diagnostic skills. Until the early 1970s chiropractic training, which was developed outside the orthodox health care training system, did not have access to a properly accredited science or clinical courses. The American colleges which had more developed facilities for the teaching of the biological and clinical sciences courses were outside the influence or control of Australian accrediting institutions. As such, they were not considered suitable programmes to provide a basis for training Australian health care practitioners.

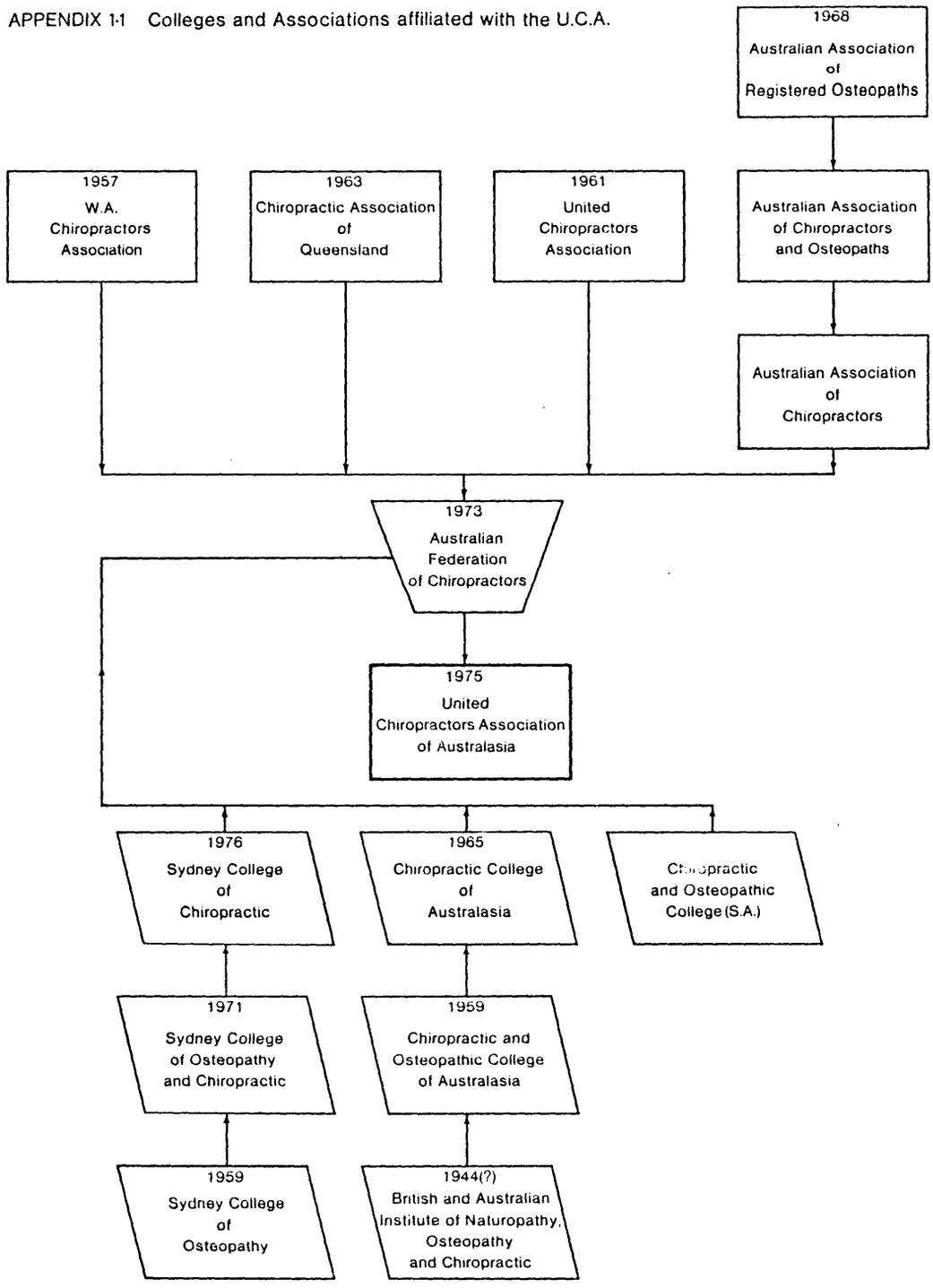
The medical argument against the adequacy of training of chiropractors had more impact than their criticisms of the chiropractors' scientific credibility. This was because claims about the direct link between the length and scope of training, on the one hand, and the competency of practitioners, on the other, were generally accepted by the state agencies investigating chiropractic. However, the argument that the standards of training and training facilities needed improving was also used by the chiropractors themselves. The major associations representing the chiropractors argued that the poor state of training facilities, like the lack of research, was due to the exclusion of chiropractors from the orthodox health care and tertiary education systems. They maintained that political recognition would help the occupation gain access to the educational and research facilities which would then

enable training programmes of a suitable standard to be developed. This is, in fact, what happened.

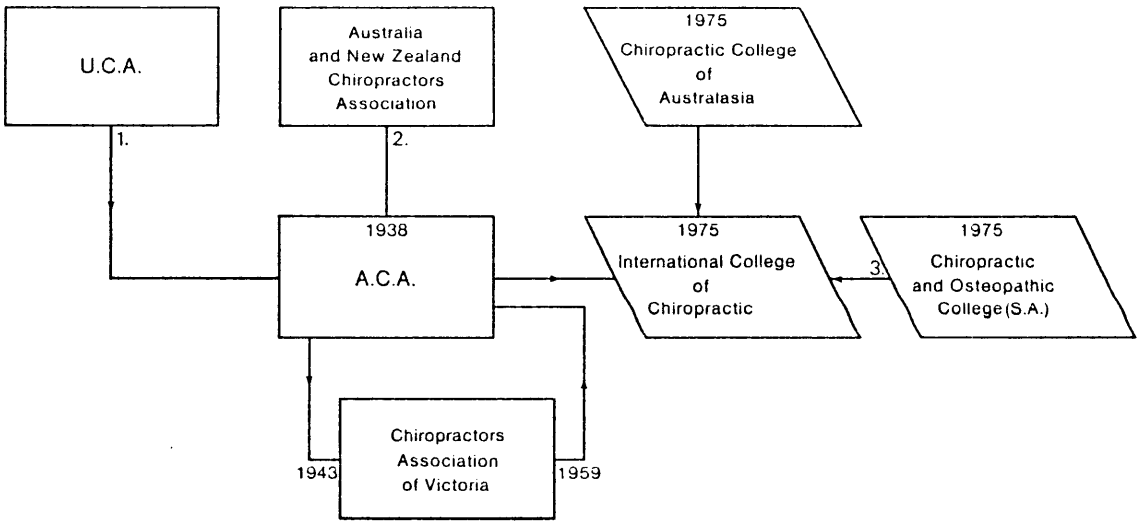
Once again, the development of the training programmes indicates the importance of external relations as well as internal power struggles. The significance of both issues has not simply been in terms of the control of the occupation by a particular faction, as it was perceived by many of the practitioners involved in the internal struggles. They are also crucial to an understanding of the reasons for the survival and development of the occupation in the Australian health care system. The history of chiropractic indicates that the modern health care system is still subject to change. It is important, therefore, that sociologists who examine occupations in this area take account of these changes. The explanation of occupational change must take into account the role of consumers and other occupations in determining an occupational identity, as well as the role of the state in establishing an occupational territory. It would be impossible to give a proper account of chiropractic without reference to these factors. Likewise, it would not be possible to give a proper account by only referring to external relations and ignoring the internal development of the occupation. The role of the professional associations and training institutions, in particular, stand out as crucial to the development of the occupation. An externalist account of an occupation, then, is not one which rejects the internalist

approach to this area of sociology, but is one which goes beyond it and, hopefully, incorporates the best features of internalist modes of analysis.

APPENDIX 1·1 Colleges and Associations affiliated with the U.C.A.



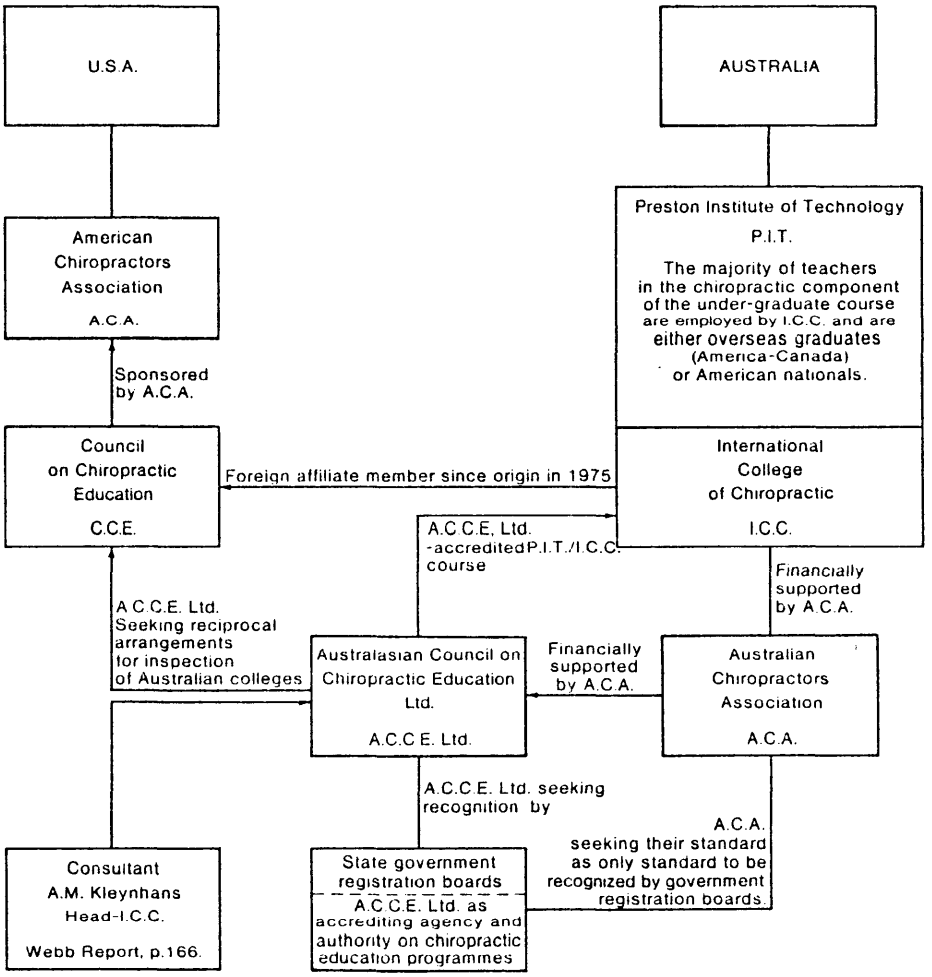
APPENDIX 1·2 Colleges and Associations affiliated with the A.C.A.



1. The A.C.A. began accepting members in Victoria and South Australia in 1974.
2. There do not appear to be any formal links between these two associations.
3. Some students and staff went to the Sydney College of Chiropractic

APPENDIX 2 U.C.A. perception of American dominance

THE MASTER PLAN



U.C.A.A. Newsletter 31-7-1980