2.5 CONCLUDING REMARKS

The theoretical underpinnings of the functionalist paradigm create a number of substantial problems for an analysis of occupational change. The most significant is that noted by Roth: the tendency to accept, at face value, the rhetoric espoused by professionals which can obfuscate occupational interests. Others, particularly the tendency for ahistorical analyses and the failure to pay enough attention to broader institutional relationships, can be overcome within the paradigm. Most of the work which has taken issue with these points has been done within the radical structuralist paradigm. These analyses have concentrated upon the conflict between occupational interests and public or consumer interests rather than examining how the professions maintain a stable social order. In fact there has been a tendency for some of the more critical work to view the professions as agents of social control serving the interests of ruling classes or elites.

The general thrust of the radical structuralist paradigm has been to examine carefully the taken-for-granted assumptions of the functionalist paradigm. In doing so, the studies have come to focus explicit attention upon the institutional relationships neglected by the functionalists. This focus, together with an attempt to come to grips with the changes which thess occupations have undergone, has led to a more adequate understanding of the professions in

modern society. In the next chapter, the manner in which the issues discussed so far have affected studies of chiropractic will be outlined together with the conceptual framework which will be used in the substantive analysis of chiropractic.

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CHAPTER 3

SOCIOLOGY AND CHIROPRACTIC

Sociologists working within the functionalist paradigm have labelled chiropractors as marginal, semi- or deviant professionals.[1] Goode went so far as to predict that chiropractors would not become true professionals "in the near future".[2] There are three main criticisms to be made of these accounts of chiropractic. The first is that the functionalist paradigm has dominated the field. The second relates to the uncritical acceptance of medical rhetoric, while the third is the failure of the authors to assess the manner in which state political and legal processes have affected the development of the occupation.

Just as sociological accounts of professionalism have been dominated by the functionalist paradigm, so to, has the sociology of health and illness developed under the same paradigm.[3] In both these areas it has been assumed that the occupation of medicine necessarily plays a role which is beneficial both to society and to the consumers of health care. The area of sociology which has dealt with any aspect

of health or illness in a society has been called "medical sociology" rather than the "sociology of health and illness", thereby reflecting the degree of acceptance of both the values and the dominance of the occupation of medicine in this field.[4] While not denying the positive contribution which medicine has made to the improved conditions of social and physical life, one has to be careful not to mistake medical rhetoric for a social fact.[5] The development of modern medicine is not the sole reason for improvements in modern life. The acceptance by sociologists of the medical world view can be at least partially explained by sociologists themselves having been engaged in the project of professionalisation and recognising the pre-eminent position of medicine vis-a-vis the professional world they have wished to become an ally rather than an opponent of such a potentially powerful patron. However, more recently, the medical dominance of this area of sociology has come under attack by some writers. In these critiques one can find a parallel to the criticisms of the functionalist accounts of professionalisation, namely, a claim that the rhetoric of the respective occupations cannot be taken for granted.

The problem of professional rhetoric influencing sociological analysis is compounded when dealing with an occupation such as chiropractic. Not only does the sociologist have to be wary of uncritically accepting the chiropractors' rhetoric, but he or she also has to view the

rhetoric of medical practitioners with critical detachment.[6] The stance of the medical associations has been openly hostile to chiropractic. Indeed, it has been hostile to any group of health care practitioners practising without the auspices of medical patronage. Although the rhetoric of both chiropractors and medical practitioners needs to be taken into account when examining the social processes which have affected chiropractic, neither is sufficient to explain those processes.

The problem of taken-for-granted values in medical sociology also reflects the main assumption of what has been defined earlier as a major problem of the functionalist paradigm in sociological analyses of the professions. This is the assumption that professionals are concerned with the interests of society before their own. The main problem with most of the work on chiropractic by social scientists is that it has tended to be descriptive and has not attempted to analyse the dynamic nature of professionalisation. Mostly, this work has assumed that medical practitioners, as members of an archetypical profession, have always acted in the best interests of society whereas the chiropractors, because they were not considered to constitute a "true profession", have been motivated by self-interest. The problem here is that when the relations between chiropractic and medicine are considered, the latter tends to appear as an authoritative source and the occupational interests of medicine are

underplayed.

Medical practitioners have tended to support those social scientists who have been working in areas useful to the delivery of medical care. Investigation of a group of practitioners who have been seen to be acting against the interests of health care consumers was unlikely to be encouraged. The lack of interest on the part of medical practitioners is reflected in the small number of articles on chiropractic appearing in medical journals. Sheehan has found that in the period between the "discovery" of chiropractic, in 1895, and 1956 there were only 50 articles in medical journals, while between 1960 and 1967 there were only 188. This number is extremely small in terms of the total number of medical publications over the same time.[7]

The position with regard to chiropractic research is slowly changing as more social and natural scientists begin to seriously investigate chiropractic and as research funding organisations make more money available for research into this area.[8] In Australia it was only after the publication of the Webb Report, in 1977, that the Australian National Health and Medical Research Council made funds available specifically for chiropractic research.[9] Access to, and control of, research funding constitutes an essential economic base to enable the scientific legitimation of technically based occupations such as medicine and chiropractic. As such, these elements become important factors to be taken into account when considering

the question of occupational status. However, it will be argued that the thrust for scientific legitimation comes after an occupation has achieved some political legitimation. It is the occupation of medicine which has placed the stress upon scientific legitimation before political legitimation. Without wishing to impugn the motives of medical practitioners, it will be shown that this strategy is a part of medical rhetoric rather than scientific discourse.

3.1 WARDWELL.

The first major sociological study of chiropractors was undertaken by Wardwell in Massachusetts in the late 1940s. At that time chiropractors were not licensed to practise in that State and were liable to be prosecuted under the State Medical Act. The study remains an excellent account of chiropractic practice of that period although it is not a satisfactory account of the process of professionalisation, or rather, the failure of chiropractors to professionalise. This is not surprising since Wardwell set out to examine the problem of how chiropractors adjust to their marginal social role. He did not expressly set out to analyse the dynamics of professionalisation of the occupation.[10]

While it is true that American chiropractors, in the late 1940s, occupied a marginal position compared to the medical profession, it is also important to realise that the occupation was striving to upgrade its position in the

American health care system. Wardwell has used role theory to tackle what are essentially psychologically oriented problems related to personal needs. He has not described, let alone analysed, the social structure of the professions in American society. In this regard then, one has to be wary about using Wardwell's work in the context of professionalisation. The marginal position of chiropractors has a political cause which tends to be overlooked in the psychological orientation used by Wardwell.

Wardwell has argued that the hierarchy of the professions was based on the public's evaluation of an occupation together with a measurement on a scale derived from scores given for conforming to a set of attributes.[11] Thus his work can be located within the functionalist paradigm described in the previous chapter. The attributes he used were: technical competence, scope of practice, legal status, income and prestige. This type of approach failed to deal with the actual mechanisms whereby one occupation, in this case medicine, gained a degree of legitimacy where it could define other occupations, such as chiropractic, as marginal. By taking for granted the legitimacy of the medical practitioner's role, the roots and reasons of that legitimacy remained unquestioned. The influence of the rhetoric of the medical profession upon sociology was, to a large degree, unquestioned by Wardwell. (In fairness to Wardwell, this is not surprising since this issue did not become a significant part of the discourse of

the social sciences until over twenty years after he undertook the study.)

He did, however, deal firmly with the rhetoric of the chiropractors. This was done via a discussion of the ideology of chiropractic. This ideology was seen as the "ideology of an oppressed minority". For Wardwell, this ideology was used by the chiropractors to explain their "unfortunate social position and their unhappy relationship to the medical profession".[12] Such an ideology was seen as functional for the chiropractors because it helped them to resolve the tensions generated by their marginal role. At the same time, there was the implication that it was dysfunctional for the public since it was used by chiropractors to "explain failures as well as cures" and to rationalise obtaining money and power "by means that [were] considered unethical or illegal".[13] The use of advertising was seen as indicative of the unprofessional nature of the chiropractor's role, as was the concern of the chiropractic associations with legislation.[14] However, the model for professional behaviour which Wardwell used was heavily influenced by the medical model of professional behaviour.

Wardwell postulated three main functions of the marginal role of chiropractors. These were related to the chiropractor, the chiropractic patient and society. For the chiropractor this role was seen as satisfying certain psychological needs such as "getting ahead in the world", nurturance, rebellion and leadership. Also important were

social needs such as social mobility. The functions fulfilled for the patient were also seen as being mainly psychological. Chiropractic was said to help hysterical manifestations, to give patients the satisfaction of being treated as a whole person, to have psycho-somatic effects similar to magical cures and, finally, to treat some organic complaints more effectively than medical treatment. The main benefits for society were, according to Wardwell, that the role provided a channel for innovation in therapeutic knowledge and technique, contributed to a decrease in the excessive use of drugs by medical practitioners and stimulated research into physical medicine and biophysics.

Coulter has argued that Wardwell's contribution to role theory has been unsatisfactory and that Wardwell misused the concept of "marginal man" with which he underpinned the notion of the "marginal role" used to describe chiropractors.[15] However, an even greater problem for a sociological account of professionalisation is that Wardwell's functionalist explanation does not explain why other unorthodox healing practices such as homeopathy or mesmerism, which fulfill similar functions, have not survived while chiropractic has.

For Wardwell, events or factors which did not appear to serve any function and which therefore could not "be brought into a system of empirical generalisations are 'historical accidents'".[16] His socio-historical analysis consisted of an account of "more important 'accidental' factors

social needs such as social mobility. The functions fulfilled for the patient were also seen as being mainly psychological. Chiropractic was said to help hysterical manifestations, to give patients the satisfaction of being treated as a whole person, to have psycho-somatic effects similar to magical cures and, finally, to treat some organic complaints more effectively than medical treatment. The main benefits for society were, according to Wardwell, that the role provided a channel for innovation in therapeutic knowledge and technique, contributed to a decrease in the excessive use of drugs by medical practitioners and stimulated research into physical medicine and biophysics.

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the current status of the chiropractor and his relationship to the medical profession".[17] These "accidental" factors included the gap between chiropractors and medical practitioners; the lack of communication between associations representing the two groups before legislative committees; and the social barriers created by the different class origins of the different types of practitioner. They became a convenient category to hold whatever did not fit into the psychologically oriented functionalist explanations that Wardwell relied on.

By considering functions as the criteria of explanation he was able to relegate the problems of medical hegemony and occupational conflict to this residual category. Similarly the role of the state became a non-issue except in so far as it supported one of the specified functions of chiropractic. The main problem with this type of account is that it is essentially ahistorical, describing a particular social situation rather than seeking to explain how that situation developed. Social change and occupational conflict do not constitute a prominent place in the analysis. I would claim that both of these factors are essential for an understanding of chiropractic. Also, both require a methodology which incorporates historical analysis as a prime concern, rather than one which treats history as a residual category.

By incorporating aspects of the medical model of what was appropriate professional behaviour, particularly emphasis on systems of referrals to specialists, seeking hospital staff appointments and emphasis on educational development and research, Wardwell has set criteria for judging the professionalisation of chiropractors which are not appropriate for that purpose. The problem is that the constructs of this model are assumed to be value-neutral. In point of fact, the constructs reflect the values of a medically dominated health care system: a system which excludes non-medical practitioners. Further, by using history as a supplement to his analysis rather than as an integral part of the account and largely ignoring the power relationships between occupations, Wardwell has succeeded in describing the position of chiropractors in the 1940s and 1950s but he has not adequately explained this position. The problem is that Wardwell's work has been, until recently, the only substantial study of chiropractic. As such it has not encouraged a rigorous investigation of the factors which have affected the professionalisation of chiropractic. Rather, it has reinforced the taken-for-granted "fact" of the chiropractors' unprofessional status.

3.2 MILLS AND ROOTMAN.

Whereas Wardwell explained the position of chiropractors in terms of the functions chiropractic played for chiropractors, patients and society, Mills and Rootman were more concerned with the relationship between legislation and professional behaviour. Like Wardwell they attributed the professional status of chiropractic to the views of those "elements in the community it is trying to serve".[18] However, they distinguished two distinct dimensions of community sanction: the formal and the informal. The former was to be found in the legal structure which controlled the occupation. These formal sanctions were dependent upon "public legitimation of power". Public legitimation was seen as the crucial factor which allowed the chiropractors to encroach upon the "traditional territory of medicine". The authors then proceeded to give an account of an empirical study which was based on an attribute approach.

In this study they measured the professional behaviour of chiropractors against an index of ten items. These items included the use of advertising, the employment of a registered nurse, subscription to journals, location of the practitioner's office in a "professional" building, and membership of professional associations.[19] They found a positive correlation between measured professional behaviour and legislation. The chiropractors who had high scores for professionalism tended to be located in provinces where

there was some form of licensing.

In a later article the same authors used a similar approach to compare the degree of professionalisation of American and Canadian chiropractors. Holding the age of the chiropractors constant and only comparing chiropractors in states or provinces where they were registered, Mills and Rootman found Canadian chiropractors to be more professionally oriented than their American counterparts. They explained the differences in terms of different survey design and administration, the state of the profession at the time on study, and different social values held by each society.[20]

The value of this work is that it highlights the importance which political factors play in determining professional behaviour. By positing public legitimation as the criterion for professionalisation the authors begin to approach an explanation of the dynamic nature of this process. However to properly understand the notion of occupational power and occupational territory, the relations of chiropractic to other institutions, especially legal, political and health institutions need to be explored in greater detail than Mills and Rootman did. The authors noted that a study using historical and social data would be necesary to explain this relationship.

3.3 COWIE AND ROEBUCK.

Mention must also be made of Cowie and Roebuck's Ethnography of a Chiropractic Clinic.[21] This study used a symbolic interactionist perspective based upon participant observation. The aim of the work was to examine the consequences of the marginally deviant status of an individual chiropractor. Although the historical development of the occupation is dealt with, the focus of the study on an individual person did not allow for a rigorous analysis of the influence of historical events. Nor was any serious attention paid to the manner in which inter-occupational relationships affected the position of chiropractic as an occupation. The substantive data aimed to:

> attempt to convey the behavioural actualities of a chiropractic practitioner, his staff, and his patients within an unconventional behaviour setting of the practitioner's own design.[22]

The work is a useful account of the structure of a chiropractic practice and also of the relationship between a set of ideas (particularly those learnt in the training school) and that practice. However, the focus upon analysis of individual deviance directs attention away from the development of chiropractic as a occupation. This diminishes its validity as an ethnography since the study fails to come to grips with the culture of chiropractors beyond the single clinic studied.

3.4 MCKORKLE.

McKorkle used cultural values to explain the position of chiropractic.[23] He maintained that the survival of chiropractic in the mid-west of the United States could be attributed to the practitioners' conforming to the rural, practical Christian values held by the people of Iowa. He saw the influence of such values as being reinforced by the less effective and less sympathetic treatment provided by medical practitioners. His analysis is ethnocentric, in that it does not account for the spread of chiropractic to the east coast of America let alone Canada, Australia or Europe. Like Cowie and Roebuck's work, the usefulness of this account is diminished by the failure to relate the development of chiropractic occupation to factors external to the occupation in any meaningful way.

3.5 MORE RECENT WORK.

White and Skipper attribute the the marginal position of chiropractic to the incompatibility of chiropractic theories with medical theories.[24] This moves past the attribute approach of simply using the presence of theoretical knowledge as a necessary criterion for claiming an occupation to be a profession, to a position which recognises that there are some factors external to an occupation which can affect its social position. In particular, they recognise that some form of legitimation of the knowledge base of an occupation is necessary for the

legitimation of the occupation itself. However, it is a mistake to see the legitimation of an occupation solely in terms of the legitimation of its knowledge. An occupation can gain political acceptance even if its theories have not been rigorously tested or proved. Such has been the case with chiropractic, although the more radical tenets of chiropractic philosophy have been down-played in the process of political legitimation.

More recently, an entire issue of the journal Sociological Symposium was devoted to studies of chiropractic.[25] While the articles in this issue included some of the more traditional approaches to professionalisation, in some papers there is an indication of a shift in the stance which these sociologists have adopted toward chiropractic. In particular, the problems caused by the medical dominance of sociology with regard to adequate accounts of chiropractic were given explicit recognition.[26]

Wardwell's contribution, while still emphasising the marginal position of chiropractors, noted that chiropractic had become an established healing profession.[27] He saw four events as marking the significant transformation of the occupation. These were: the recognition of chiropractic by all American State legislatures, the recognition of the Council of Chiropractic Education (established by the chiropractors to accredit chiropractic curricula in the U.S. colleges) by the U.S. Office of Education, the

payment of chiropractors' fees by Medicare and, finally, the granting of two million dollars by the National Institute of Health to study chiropractic.[28] From this it can be seen that Wardwell's change in stance can be attributed to his recognition of the importance of political legitimation in the process of professionalisation.

Nofz also took up the question of the changing legitimacy of chiropractic.[29] He examined the role of the paradigms within which chiropractic "knowledges" are located. His argument was that these paradigms have played a crucial role in maintaining the marginality of chiropractic. He sees the change in paradigm as being important in the transformation of the social position of the chiropractors. Nofz's argument is similar to that adopted by White and Skipper. Both stress the primacy of the role of knowledge in determining the status of chiropractic. However, neither assess the role of the medical profession in determining what is valid knowledge, nor do they effectively relate the legitimation of knowledge to the political processes which determine occupational boundaries within the division of labour of the health care system.

3.6 AN ALTERNATIVE APPROACH TO CHIROPRACTIC.

In general, sociologists studying chiropractic have followed the tendency of sociologists studying the

professions by working mainly within the functionalist paradigm. This is apparent in the crucial position of community sanction (whether it be the scientific community or the community of consumers) in the explanations of the position of chiropractic. It is also apparent in the lack of analysis of power relations in determining the position of the occupation. The has also followed the trend of medical sociologists to accept the hegemonic position of medicine. More recently, sociologists interested in the study of chiropractic have begun to move away from this position to one which is more concerned with social change and power relations in the analysis of occupations and professions. Coulter and Willis are furthest down the track in this regard.

Coulter has argued that the knowledge base of chiropractic together with the social acceptance of paradigms is important for the acceptance and legitimation of an occupation. He points out that:

> Legitimacy . . . even in a "rational" society, is not determined by the truth of knowledges. If it was, much of the so called medical knowledge of both past and present would not have been legitimised.[30]

He stresses that the acceptance of knowledge as legitimate results from a power struggle, both within and without the occupation.[31] That is, Coulter sees the legitimacy of knowledge as being determined by political factors.

Willis has tackled the problem of the legitimacy of chiropractors in the Australian context in his review of the Webb Report.[32] Here he examined the relationship between clinical legitimation (legitimation of a therapeutic practice by patients attending clinics where that therapy is practised) and legal legitimation. Willis' is the only account of chiropractic which explicitly rejects the attribute approach to professionalisation in favour of an approach which emphasises professionalisation as a historical process. Thus he sees professionalisation as being aimed at:

> gaining control over an "occupational territory" -- that is the exclusive right to administer a body of knowledge to an area of human affairs.[33]

The substantive analysis of chiropractic in Australia will follow in the vein of Coulter and Willis. I will examine the changes which chiropractic has undergone as an occupation since its emergence in Australia shortly after the First World War. In doing this, I will use the concepts "occupational identity" and "occupational territory". By "occupational identity" I mean the recognition of an occupational group as having a specific expertise. This identity is generated by the practitioners of the occupation. It is the task of the practitioners, or their representatives, to ensure that the claims of the occupation are recognised on three levels: by consumers, by the state, and by other occupations in related fields. It is also seen

as inevitably preceding the establishment of an occupational territory. An "occupational territory" is established by formal structures which give practitioners of the occupation the legal right to perform specified tasks. The forging of an occupational identity will be shown to be largely determined by power relations in the same way that an occupational territory is. These power relations operate at four levels. These are:- within the occupation itself; between an occupation, as a producer of a service, and the consumers of that service; between the occupation and other occupations; between the occupation and the state. (I will refer to the Federal and State legislatures, together with their respective bureaucratic agencies, as "the state".)

Before proceeding, it will be useful to point out that, while the direction of the following substantive analysis is heavily influenced by the radical structuralist approach to the professions, some of the issues raised by the functionalists will be the focus of attention. For example, to use the concept of clinical legitimation to examine the relations between consumers and producers of chiropractic care is analogous to the use by some functionalists of positive community sanction as a necessary condition for professionalisation. However, the notion of community sanction in this work is not viewed as an independent variable as it is in most functionalist accounts but, rather, as an element in the overall struggle betwen chiropractic and other occupations which have opposed that

occupation's legitimation. In this context it is significant that the occupation came to be identified as chiropractic and not as a part of naturopathy, physiotherapy or medicine.

Also, the formation of professional associations and the role of training programmes will constitute a major part of the analysis. The means of transmission of the skills or knowledge upon which the expertise is founded is crucial for the continuity of an occupational identity over any length of time. However, I will move in a direction different from that of the functionalists since the aim of dealing with such themes is to analyse the occupational conflict which has been an integral part of the history of chiropractic in Australia. These elements have been mobilised by the chiropractors in their task of securing the identity of their occupation and subsequently establishing an occupational territory. The establishment of occupational identity, in the case of chiropractic, was closely linked to clinical legitimation. After chiropractic had been legitimated at this level it then mobilised the support of patients to achieve political recognition. Only after achieving political recognition, did chiropractic achieve a position whereby it could wield sufficient power to mobilise the resources to embark upon a programme of scientific legitimation.

The explanation of the changes which have occurred in the occupation of chiropractic is to be found by studying the relations between the occupation and broader social and political processes, concentrating upon the interests of relevant groups rather than the adherence to an ideal of service. It will become apparent that political factors have played a much more important part in the legitimation of the occupation than the scientific validity of its knowledge base. One of the results of rejecting the functionalist paradigm as being able to provide the basis for an adequate theoretical explanation of occupational change is that occupational rhetoric is not taken at its face value. However, I do not wish to claim that chiropractic does not provide a useful and beneficial service to the community. In fact, the perceived effectiveness of chiropractic therapy constitutes a crucial aspect of the legitimisation process. At the same time, I do not wish to imply that the occupation of medicine, because of its opposition to chiropractic, does not provide services which are essential to maintain the quality of life in modern society. What I do wish to show is that the factors which have affected the development of chiropractic are those concerned with occupational self-interest, not the ideal of service which the functionalists have maintained is the guiding principle to understanding the professions.

The process of professionalisation is the political legitimation of an occupation's expertise which gives that occupation a defined place in the division of labour with a legally defined status and specific privileges. This definition departs from those used in functionalist accounts because it emphasises the political dimension of the process. To make clear the reason for emphasising this political dimension it is useful to return to Gilb who distinguished between a professional association as a pressure group and a professional association as private government.[34] As private governments, associations can act as "preliminary arenas of public lawmaking".[35] In this capacity that they can most effectively establish an occupational territory. As a pressure group, on the other hand, they must first introduce the validity of the occupation's claim to a unique and autonomous identity and justify the occupation's identity and practice within the current social, political and economic milieu.

> A pressure group is one that does not have fully developed access to public government. Most professional associations are in such a position at one point in their development. Incompleteness of access is in part a result of lack of unity on legislative issues which has characterised the early stages of most professional organisations in whatever decade those early stages have come . . . Under these circumstances the legislature was likely to be wary about adopting any programme; it was more apt to listen to professionals who were more involved in politics than professional activities and who might even be hostile to the professional association and its leaders.[36]

As a private government, the professional association can become the source of legitimation both for itself and for other related, and perhaps competing, occupations. (When dealing with competing occupations it would be expected that such an association would aim to prevent or restrict the legitimation of the competition.) Initially, the chiropractors must be considered as a pressure group since they have had incomplete access to the various arenas of policy making which have affected their training and mode of practice. The process of legitimation of this occupation has been characterised by the attempt of chiropractors to establish their credentials as a private government. This has meant gaining acceptance as an autonomous health care occupation with specific expertise in their given area. The occupation of medicine, on the other hand, has had the benefit of being considered the authoritative occupation in the health care field. As such, medical practitioners have had ready access to the arenas of public lawmaking either directly, by representing political parties in the legislatures, or through informal "old boy" or family networks. The A.M.A. has opposed chiropractic by using both formal and informal approaches to government, although it is extremely difficult to get concrete evidence of the way in which the informal structures actually work.

However, access to public government is, in itself, not enough to ensure success in the legislative arena. Theoretically, in a democratic state, all people and groups

have access to public government. However, some groups do have more influence than others. It is in this context that the concept "private government" is important. Those associations with established channels to public government will be in a stronger position to influence the direction of relevant political processes since their advice is likely to be sought, formally or informally, before the legislature takes any decisions affecting their area of expertise. The chiropractors, as a pressure group, have opposed the medical hegemony through political lobbies, especially through submissions to Government Committees of Enquiry or Royal Commissions. They have had to argue, in both informal and public arenas, that they are a legitimate source of expertise about a particular type of therapy -- the adjustment of the vertebral and related joints.

One of the main aims of an occupation establishing an occupational territory is to gain autonomy within that territory. Autonomy has been posited as one of the key characteristics of a profession and an important aim for those occupations aiming to professionalise.[37] An autonomous profession is one which virtually legitimates itself. Autonomy, in this sense, tends to be legitimated by expertise. However, the expertise, in turn, has to be legitimated, implicitly or explicitly. Implicit legitimation has been taken up by social scientists working within the functionalist paradigm. It is legitimation by consensus, by the assumed conformity of the values held by

practitioners with the values of society or because the occupation is seen to play a key role in the maintenance of the social order. Explicit legitimation is that granted by the state through its legislative or bureaucratic organs.

Recognition of an occupation's expertise by the state is crucial to its development along the path of professionalisation. Apart from anything else, state recognition enhances an occupation's ability to gain access to benefits such as third-party accident and workers compensation insurance claims. These provide an effective consolidation of the occupation's economic base. Also important in the conslidation of an economic base is state support for the costly training programmes necessary to provide highly qualified professionals. The political legitimation of an occupation is dependent upon the development of a training programme accredited and financed by the state. More important, however, is the role which the state plays in allowing occupational self-regulation.[38] This is particularly so with regard to control of training programmes.

In Australia the accreditation in non-university tertiary education institutions is undertaken by authorities attached to State government Education Departments: the Higher Education Board in N.S.W. and the Victorian Institute of Colleges in Victoria (now the Victorian Post-Secondary Education Commission). The professional associations, or their representatives, can play an

important role in the accreditation process by giving advice on the suitability of curricula of the training centres. In this way the professional associations can influence the occupation through control of the standards and scope of training. The actual mechanisms of control are often to be found in the bodies which register or license practitioners. As an occupation becomes the source of expertise by which it can be assessed by the state, the associations representing that occupation play an increasingly important role in controlling the occupation. They become, in Gilb's sense, private governments.

I have called public support for a health care profession clinical legitimation and legitimation of the knowledge base, scientific legitimation. While these two processes of legitimation can establish a territory, they are not sufficient conditions to complete such a process. It is legitimation at the political-legal level which constitutes the recognition of an occupational territory, since political-legal legitimation is the definition of that territory by the state. By linking the concept of an occupational territory to the state the mechanisms of occupational power can be traced.

The concept of occupational power can begin to explain some of the aspects of professionalism not explained by the traditional functionalist accounts. For example, the argument that the position of an occupation depends upon consumer support does not explain how an occupation can

increase fees against the wishes of the consumer. The striving for occupational power can be seen clearly in the (generally successful) attempt by the medical associations to consolidate an occupational territory and eliminate competition. These associations argued that it was in the public interest to do so because their members were the persons most competent to provide the respective services. Most competing, non-medical practitioners were excluded from this territory.

Occupational power is manifested through the interplay of three different types of control outlined by Johnson.[39] These are: collegiate control, whereby an occupation establishes its autonomy; mediation, whereby the state legitimates that control; and patronage, whereby a new occupation would gain political influence through support of the consumers. The process of establishing collegiate control is analagous to what I have referred to as the establishment of an occupational territory. Mediation is to be analysed through the political legitimation of an occupation. Patronage, in the case of chiropractic, has come about through consumer legitimation. Patronage will not always develop through consumer support. For example, the patronage of the medical profession has been more influential than consumer support for the development of some occupations in the health care system. Physiotherapy would be a case in point. However, patronage can retard the development of occupational autonomy if it is used to

influence state mediation in such a way as to limit the developing occupation or subordinate it to a more established occupation. Before proceeding with the substantive analysis of chiropractic, however, it is useful to examine, briefly, the development of the occupational territory of medicine. There are two main reasons for doing this. Firstly, the striking similarities between the development of medicine and the development of chiropractic allow some useful insights into the dynamics of the process of professionalisation. Secondly, the strategies adopted by the chiropractors have been heavily influenced by medical hegemony in the health care field. The latter will shed light on the nature of the power relationships which have affected the professionalisation of chiropractic.

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CHAPTER 4

STRATEGIES OF MEDICAL DOMINANCE.

In assessing the position of medicine in the modern health care system, Freidson has argued that:

> The structural position of the medical profession . . . patterns the relationships among a variety of other occupations that provide health related services.[1]

Willis has extended Freidson's argument and elaborated three mechanisms by which the medical profession dominates other occupations concerned with the provision of health care.[2] These mechanisms are subordination, limitation and exclusion. A fourth mechanism may be added to these: co-option.

Subordination occurs when an occupation comes under the direct control of an occupation such as medical practitioners. Nursing is an excellent example of an occupation subordinate to medicine. Nurses work under the direction of medical practitioners and cannot carry out many tasks in the work situation without specific instructions from medical practitioners. A more indirect form of

subordination is to be found in the referral system where a non-medical practitioner can only take charge of a client when that client has been referred by a medical practitioner.

Limitation occurs when non-medical practitioners are restricted to using a specified therapy or range of therapies, or to treating a particular type of complaint. Psychologists, for example are restricted in the type of treatment they can offer for neurotic or psychotic disorders. They are not permitted to undertake surgery or drug therapy. These must be prescribed and carried out by medically qualified practitioners. Pharmacy is also a limited occupation in that pharmacists are limited to dispensing drugs.[3] They may not prescribe restricted drugs or diagnose illnesses, although they do act, informally, as a primary contact for some health care consumers for minor complaints. The mechanisms of subordination and limitation are the two main ways in which the occupation of medicine maintains its hegemony over the increasingly diverse occupations that now constitute modern health care systems. In effect they can be said to be ways in which medicine maintains control of its occupational territory.

Exclusion is the process by which medicine, together with its limited and subordinate allies, establishes the boundary of its territory. Co-option may occur when the three other strategies have failed. This strategy can refer to either an occupation accepting the members of a competing

occupation on an equal basis, or when an occupation begins to practise the therapies of its competitor. In the latter case, the strategy of exclusion is also used. An example of the former approach is the case of American osteopaths who were permitted to join the American Medical Association from 1962.[4] In Australia, medical practitioners have urged that manipulation be co-opted by medical doctors and physiotherapists, arguing that chiropractors would then become redundant.[5] This invitation only came after decades of unsuccessful attacks on that occupation by medical practitioners.

The occupational territory of medicine has not been built about a particular therapeutic practice. Rather, medicine has attempted to control the whole field of practices concerned with health and illness. The focus of the occupational identity of medicine was initially based upon the type and scope of training. In the late nineteenth century medicine began to identify with the emerging natural sciences. At this time it was clear that medicine was far from scientific although it was seen that the methods of science could contribute much to the development of effective medical practices.[6]

Medical practitioners with more extensive training began to form associations which could represent the occupations at a political level. One of the aims of these associations was to exclude practitioners who did not have such training from the developing health care system and

raise the status of the occupation.[7] The main battle at the turn of the century was between the homeopaths and the allopaths although all unorthodox practitioners were opposed by the allopathic medical practitioners. The allopaths were represented by what came to be the dominant medical associations, the British Medical Association and the American Medical Association. The former established a branch in Australia in 1890.[8] This branch gained autonomy in 1962 to become the Australian Medical Association (A.M.A.).

In Australia, the early Medical Acts protected the identity of medical practitioners by penalising any other person from trying to use that identity until well into the twentieth century. This was done by making the act of purporting to be a medical practitioner illegal if that person was not registered by the State Medical Boards. The Acts did not stop other types of practitioners from practising.[9] They consolidated the identity of the medical practitioner. The consolidation of the occupational territory was a far more complex development. The latter entailed the development of the hospital system, the referral system whereby patients were kept within the medical territory, the expansion of educational and research facilities, and technological advances. Major innovations in the use of drugs and surgery received wide media attention, giving support to the popular notion that medicine's scientific advances were the mainstay of the occupation's high social standing.[10] This reinforced the

positive identity that medicine was gaining and helped justify the attacks on medical competitors as quacks and charlatans. In short the development and consolidation of the medical territory involved a process whereby medical practitioners became the authorities about, not only matters relating to illness, but all matters affecting human health.

It is in this context that the mechanisms of exclusion, subordination, limitation and co-option were used. Those practitioners who held a competing theory of disease or had less extensive training than the medical practitioner, it was claimed, provided a risk to the lives of the public. The argument was put forward that such practitioners were quacks or charlatans and should, in the public interest, be prevented from practising. Governments were, however, wary of taking away the livelihood of persons who had some form of clinical legitimation and the political process tended to work by identifying who was a legitimate medical practitioner and not by prohibiting the unorthodox practitioner. The occupational territory of medicine was consolidated as the political and legal processes actually prohibited other occupations from practising particular therapies or treating certain complaints. The most obvious form of political legitimation was registration.

Any official recognition of an occupation had to be justified in terms of parameters which avoided any obvious commitment to specialised interest groups. The public safety issue provided a legitimate avenue for pursuing

legislation which could enhance the position of an occupation without obviously favouring the occupational group over the interests of the general public. If the state was to bestow a degree of legitimacy upon an occupation, then, it was argued, there must be some means whereby a minimum standard of competence could be ensured in order to protect those who were dependent upon the services of that occupation. This standard was to be measured by the depth and scope of professional training. The legitimacy of an occupation was thereby directly linked to the legitimacy of the training institutions which produced the practitioners.

The establishment of medical training in universities gave that occupation a well-established source of legitimacy. However, the fact that training has been historically located in universities has not always been an indication of its adequacy. Carr-Saunders and Wilson have claimed that social, not learning, qualifications were of primary importance in the two most prestigious British universities, Cambridge and Oxford, in the eighteenth and nineteenth centuries.[11] Graduation from these universities was a requirement for membership of the Royal College of Physicians. The rise of the apothecary-surgeon during this period, which finally resulted in the equality of legal status between these practitioners and physicians under the 1758 Medical Act, can be attributed to the well developed training programmes of the former together with their

organisation into an association which could effectively represent these practitioners both at the broad political level and in negotiations with the dominant occupation, physicians. The dynamic of professionalisation is to be found in the interplay between the associations representing the various occupations, the educational institutions where practitioners are trained and the legal and political institutions of the state.

It is in this context that professional rhetoric has played an obscuring role because, in order to establish political legitimacy, the practitioners and their representative associations have had to argue in terms of the public safety issue and play down the notion of establishing an occupational territory. The rhetoric of the different occupations concerned with the issue of registration of chiropractors can be seen as masking their real interests. However, the claim that the rhetoric was generated solely to support economic or other occupational interests must be emphatically rejected. Rhetoric is generated from the images professionals have of themselves and other aspects of the social world, including other practitioners. This is usually underpinned by an assumption that these images are "the true state of the world" and, therefore, do not require critical investigation. Re-evaluation of such assumptions generally comes from influences outside the occupation.

4.1 THE STRATEGIES OF EXCLUSION AND CO-OPTION.

The opposition of orthodox medical practitioners to a therapy such as chiropractic is not surprising. The consolidation of the occupational territory of medicine entailed the exclusion of unorthodox healers from, what came to be, the legitimate, state supported health care system. How this consolidation came about is beyond the scope of this present study. However, a brief outline of some elements of this process must be sketched in order to grasp the relationship between medicine and chiropractic.

Medicine, as an occupation, has adopted the same stance toward chiropractic as it has toward other non-orthodox therapies: it has attempted to exclude them from the health care system. Homeopathy and bone-setting are examples of two occupations successfully excluded from the Western health care systems. The associations representing the homeopaths, for example, were not able to protect the identity of their occupation as a distinct therapeutic modality.[12] This was especially so in the light of the technological advances which facilitated therapeutic successes for allopathic practitioners. Particularly important were the development of anaesthetics, antiseptics and pharmaceuticals which allowed for successful medical intervention in areas previously thought hopeless. Thus, homeopathy was opposed and successfully excluded from the health care systems.

Bone-setters were also seen as a threat to public health and, in the late nineteenth and early twentieth centuries, as a threat to the purses of medical practitioners. Later, when the chiropractors and osteopaths emerged, and medicine had established its credentials as a science, the associations representing medical practitioners emphasised two themes in their opposition to unorthodox practices. These were: (1) the importance of a scientific explanation of disease and (2) an adequate training. Opposition to unorthodox practitioners was seldom couched in economic terms or supported publicly in the context of preserving the interests of the occupation of medicine.

Initially, the bone-setters were criticised for their lack of training and their crude, sometimes violent techniques. Later, as the chiropractors and osteopaths began to formulate coherent theories to explain their therapies, the medical practitioners began to emphasise the lack of scientific credibility on the part of their rivals, a strategy which had been successful in excluding the homeopaths. Also, they attempted to incorporate some of the practices within the medical regime. However, as the scope of medical territory expanded, the increased division of labour within the health care sphere meant a greater number of occupations were necessary to perform medical tasks. Physiotherapy became the legitimate occupation which incorporated techniques of manipulation. The domination of the physiotherapy curriculum by medicine and the

subordination of physiotherapy practice to medical practitioners meant that the unscientific aspects of such practices as chiropractic could be avoided.

Thus the medical argument against recognition of chiropractors came to be premised upon the unscientific aspects of the chiropractic theory of disease together with their inadequate training. Claims of successful treatment were dismissed as psychosomatic cures or due to the self-limiting nature of the complaint. This stance was supported by the argument that physiotherapists were capable of manipulating patients where necessary and therefore there was no need to duplicate existing training facilities by funding chiropractic training.

The advocates of homeopathy were excluded from the mainsteam health care system by the orthodox medical associations. They were relegated to the realms of the unregistered and, therefore, attacked as quacks and charlatans. While there are still a few homeopaths practising in Australia to-day most are not registered medical practitioners, although there are a few medical practitioners who still practise homeopathy. For the most part, homeopathy has become a part of the repertoire of alternative practitioners, often taught in an ad hoc fashion with little integration with other courses, such as anatomy or pathology, which have come to be an integral part of the training of the modern health practitioner.

With regard to bone-setters, some medical practitioners have advocated the virtues of bone-setting and, later, manipulative therapy. They have not, however, advocated the development of such practices outside medicine, but have urged medical practitioners to learn such skills so that lay persons would no longer be able to perform the tasks which need to be carried out by qualified medical practitioners. In other words, they have followed the strategy of co-opting the therapeutic practices while, at the same time, attempting to exclude the practitioners who developed these therapies.

The attitude of nineteenth century Australian medical practitioners toward their more unorthodox counterparts is reflected in a lecture given by Mannington Caffyn in 1883 on "Quacks and Quackery". Caffyn delivered a scathing attack on bone-setters, homeopaths and Mrs. Armstrong. (Mrs. Armstrong was a herbalist who practised in Melbourne using divination as a form of diagnosis.) In this lecture he suggested that there was "some grain of truth lying hidden at the foundation of bone-setting".[13] The aim of his attack was to forewarn legitimate medical practitioners about such practices. Although he did not believe that bone-setting was practised in the Colonies at that time he expected it to appear, given its popularity in Britain.

In his attack on the homeopaths and Mrs. Armstrong, Caffyn emphasised the lack of scientific or rational explanations given by such practitioners about the cause and nature of illness, together with their lack of proper training. Discussing homeopathy, he claimed that it was only a few years since:

> . . . the whole question was ventilated in the columns of the Lancet, and its rank absurdities pointed out and it is only fair to add that every recognised leader among the disciples of Hahnemann at home [i.e., England] publicly repudiated any and all allegiance to the two laws that form the whole foundation of the principle of homeopathy.
>
> The attitude of regular medicine towards homeopathy has been abundantly justified in innumerable instances, not only by their own confessions, but also by the discredited position of homeopathy throughout Europe, where, look where you will, you cannot find a single chair devoted to its development; and yet we have been accused of being actuated by feelings of jealousy, and other base motives, in declining to allow them to join the British Medical Association, and mix with us on terms of equality.[14]

The need for proper training was again emphasised when Caffyn dealt with Mrs. Armstrong:

> . . . I could but wonder at Mrs. Armstrong not taking the trouble to read up a little medicine, so that, when thrown upon her own resources, her remarks might have something to commend them.[15]

Caffyn was also aware that medicine at that point in time, was still not a complete science:

> Medicine has never yet been placed upon a satisfactory scientific basis; and why? I think the all-sufficing answer

> is, because it is so essentially an empiric science -- i.e., one founded entirely upon experience. The whole system of medicine contains but few exceptions to this law, and even these, upon closer examination, will be found to belong exclusively to chemistry.[16]

The main thrust of Caffyn's argument here was that clinical legitimation was of much greater import in the development of a doctors practice than scientific legitimation, since medicine could not claim to be a fully fledged science at that time. If practitioners could inspire confidence in their clients then they could be assured of a large and comfortable practice often at the expense of the conscientious medical practitioner who tried to rationally treat and explain the ailments he dealt with.[17] The danger Caffyn saw here was that the untrained and ignorant would have been able to develop extensive practices at the expense of the qualified physician.

The case against bone-setting was put even more forcefully in Britain where bone-setting was widely practised. In 1867, Paget attacked bone-setters.[18] He did not argue that bone-setting did not work. On the contrary, he pointed out that bone-setters often successfully treated patients that orthodox practitioners failed to treat effectively. His attack was based upon the lack of training on the part of the bone-setters, and the violence of their practice. These factors made them enemies of medical practitioners. He suggested that orthodox medical practitioners should take note of these practitioners and

incorporate their methods into medicine where they would enhance the physician's practice and the patient's welfare. The patient's welfare would have been enhanced because the practitioners would have proper training and would be less inclined to use violent manipulations which could have iatrogenic repercussions.

> . . .learn . . . what you can from the practice of rubbers and plaisterers: for these also know many clever tricks; and if they had but educated brains to guide their strong and pliant hands, they might be most skilful curers of bad joints and many other hindrances of locomotion.[19]

The alternative to allowing these practices to flourish outside the territory of orthodox medicine was to co-opt them. Indeed, the success of the bone-setter in cases where eminent medical practitioners had failed and where the patient was a person of influence was seen to be detrimental, not only to the individual practitioner, but also to the profession as a whole. Such was the argument presented by Hood in 1871 when he published a treatise on bone-setting in the Lancet.[20]

Hood, together with other surgeons and medical practitioners of the time had learnt the techniques of the bone-setters and stressed the importance of encouraging these practices within the ambit of medicine.[21] However the medical practitioners did not take readily to the idea of adopting the bone-setters' trade and the introduction of

manipulation into medicine has been, largely, a haphazard affair. In the words of Cyriax:

> The position of manipulation in Medicine is bedevilled by its being no one person's business, being carried out as a side-line by various exponents. It hovers between orthopaedic surgery, rheumatology and neurology. The no-man's land enclosed within this triangle is invaded by various types of lay-manipulator, blithely stepping on ground where medical men neglect to tread.[22]

Cyriax, together with James Mennell, has argued strongly for the introduction of manipulation into the medical curriculum.[23] Mennell introduced manipulation into the curriculum of St. Thomas's Hospital in Britain in 1916, while Cyriax began teaching these techniques to physiotherapists in that hospital in 1938.[24] Their repeated attempts to get other teaching hospitals to follow suit were unsuccessful.[25]

Cyriax was extremely critical of lay practitioners, among whom he counted chiropractors and osteopaths, using manipulation. He rejected the possibility of there being any validity in these practitioners' postulates, which linked displacement of the vertebrae with organic disease.[26] At the same time, he argued against against the need for lengthy training in the use of manipulation which the osteopaths and chiropractors claimed as necessary. He was particularly critical of the unscientific postulates of both chiropractors and osteopaths. He claimed that the techniques of manipulation:

> . . . are easy to learn and there is considerable irony in the fact that my simple methods are at least as effective as the more elaborate manoeuvres used by laymen. Theirs, they insist, take many years to learn . . . Mine when taught to physiotherapy students take only a few months.[27]

Cyriax was responsible for teaching manipulation to physiotherapists in Norway, Germany, New Zealand and Australia. In the last country it was taught to a Miss Ganne, who was Vice-Principal of the School of Physiotherapy in Adelaide.

In the U.S.A., the American Medical Association explicitly campaigned for the elimination of chiropractic as an occupation. While a similar position was adopted by the Australian Medical Association, the latter association also supported the practice of this therapy within an occupation already subordinate to medicine. This occupation was physiotherapy which, while legally entitled to have the primary contact with the patient, voluntarily accepted the restriction of accepting only those patients referred by a medical practitioner.[28]

It is the process of exclusion which has characterised the medical stance toward chiropractic although there have been some attempts to incorporate spinal manipulation within the medical sphere. This co-option has mainly been undertaken by orthopaedic surgeons and physiotherapists. The techniques used by these occupations differ markedly from those used by chiropractors or even osteopaths. Some

orthopaedic surgeons, for example, manipulate when the patient is under full anaesthetic. Those who have endorsed the use of manipulation while the patient was conscious have been highly critical of both chiropractic and osteopathic techniques. Amongst the latter, Cyriax has claimed that there is a place for spinal manipulation but that physiotherapists, not chiropractors, should undertake this therapy since they work under a form of medical supervision: referral.[29] The referral system would ensure that the patient got a proper diagnosis. In effect, he has advocated the co-opting of spinal manipulation by medicine while emphatically rejecting the chiropractic philosophy and the claims by chiropractors to the right to practise as independent, autonomous practitioners.

4.2 CHIROPRACTIC STRATEGIES.

In the following chapters I will examine the changing status of chiropractic by examining how the occupation first established a cohesive occupational identity and then proceeded to develop an occupational territory. The establishment of this territory has taken place at three levels of legitimation: the clinical, the political-legal and the scientific. Clinical legitimation has entailed gaining consumer acceptance. The key to this has been the chiropractors' therapeutic success, especially in cases where orthodox medical treatment had failed. Political-legal legitimation has involved acceptance of the

occupation by the state. This has meant a long and extensive campaign of lobbying to get legal recognition in the form of State Registration Acts and political support for the government funding of colleges, access to workers compensation and third-party accident insurance cases as well as the right to practise as primary contact practitioners.

Scientific legitimation is, at this point in time, not relevant except in the failure of the medical associations' attempt to claim that chiropractic has no scientific credibility. This is mainly because the discipline has developed outside the main educational institutions and has not had access to research facilities and funding. The medical profession with access to these facilities has not undertaken any comprehensive research on chiropractic in spite of its rejection of chiropractic as an unsafe and unscientific therapy.

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