OSTEOPATHY AS A PROFESSION

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1. Introduction

The author of this report investigates the professionalization of an occupation using sociological perspectives defined by a number of recognised sociologists (Bessant & Watts, 2007; Freidson, 2001; Grbich, 2004) in researching the professional status of Australian Osteopathy. Consequently, definitions of professionalization are clarified and the use of Freidson's professionalism principles in researching Australian Osteopathy is presented. Criteria for the assessment of Australian osteopathic professionalism are derived from sociological research literature in the conceptual framework of this thesis.

Reference is made to a number of the health care systems in which osteopathy exists as a profession. The health care systems of anglophone countries are reviewed to define the current issues and professional status of osteopathy in these countries (Baer, 2004). The comparison is made as these countries have similar cultures, lifestyles, health care and political systems when compared to the rest of the world. The discipline of osteopathy in these countries is defined and compared in professional terms based on sociology.

Professionalism is reviewed in research and published literature as a sociological entity, rather than as a clinical practice entity by way of particular practitioner characteristics. Micro-level issues relating to professionalism are discussed that affect macro-level issues in the professionalization of an occupation (Newman, 2004). Principles associated with professionalization are derived from Eliot Friedson's work that documents the professionalization of medicine (Freidson, 2001). These principles are used as a basis or 'lens' to examine professionalization and the current professional status of Australian osteopathy.

Osteopathy in Australia and internationally is regarded as a complementary and alternative medicine. In many countries, apart from the United States of America (USA), osteopathy has a

restricted scope of practice governed by legislation or is unregulated. In the USA, though, osteopathy has the same scope of practice and recognition to that of medicine. USA osteopathy has maintained and advanced its professional status by addressing health care issues in society, and by promoting its existence by incorporating a number of sociological processes into its organizational structure.

Recent issues affecting society are identified in the context of health care provision. Not discussed in this chapter is the effect of these issues on the de-professionalization of medicine (Freidson, 2001), as this chapter is investigating the current and possible future professional status of Australia osteopathy. Overarching concepts emerge in regards to sociological issues that are affecting all professions currently, and possibly the future. Professions have developed from societies that have been built on lay knowledge (Gabe, Bury, & Elston, 2004; Popay, Williams, Thomas, & Gatrell, 1998), in which science has been used a framework in what is known as the *biomedical* model (Gabe et al., 2004). Failure of the biomedical model to address all health care issues has created a *socio-biomedical* model for managing the health care needs of the community. This model addresses the health care needs and provision in what is known as *evidence based* medicine, or *outcomes based* medicine.

In concluding, this chapter provides a conceptual framework for defining the current professional status and identifying gaps in research literature relating to Australian osteopathy professionalism. Research methods are determined to collect and categorize data using Friedson's principles on professionalism, Analysis of the data provides a mechanism to identify internal and external sociological and organizational issues that affect Australian Osteopathy.

2. *Review of integration of osteopathy in Australian and international health care systems.*

Health care systems differ between countries where the osteopathic discipline exists. Anglophone countries have elaborate health care systems. Australian health care should be viewed broadly, as it is delivered by both conventional (ororthodox) professions and complementary (or alternative) health care professions. In addressing the main research question of this thesis, the current professional status of osteopathy in the Australian health care system is reviewed, and is compared to the professional status of osteopathy in the US and UK.

The Australian health system is founded on the conceptual framework that was established sixty years ago by the World Health Organization (WHO) that described health as 'a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity' (cited in Australian Institute of Health and Welfare, 2004; WHO (World Health Organization), 1946). Constituents and professions in Australian health care deliver primary and secondary outpatient care through private practice, outpatient clinics and primary health care facilities funded by hospital, private health insurance companies, public and private health authorities (including Department of Veteran's Affairs, Medicare and Comcare). General or medical practitioners generally coordinate care and referrals, serving as formal gatekeepers in the Australian health care system. The government administers a compulsory national health insurance program, known as Medicare. Medicare is funded by a mixture of general tax revenue, state revenue, and fees paid by patients. The government funds 68% of health expenditures (45% federal and 23% state) and has control over hospital benefits, pharmaceuticals, and medical services. States govern public hospitals and regulate all hospitals, nursing homes, and community based general services. States pay for health services in the public hospitals via five yearly agreements with the federal government. Private health insurance companies generally cover the gap between Medicare benefits and schedule fees for inpatient services, and subsidized the provision of health services in private health care facilities. Public health authorities deliver aged care, sexual health, psychiatry, preventative disease, dental care antenatal care, child health care and screening services, which are financed primarily by the

federal government (Australian Institute of Health and Welfare, 2004), and to lesser extent private health insurance companies, Acute, secondary and tertiary care in relation to work related and motor vehicle injury is funded by state health care authorities, private insurance companies and employers. Patients are free to choose any type of health practitioner for an illness or condition.

Over the last three decades, there has been a slow shift in a highly regulated medical approach to Australian health care brought about by a holistic health care movement and the widespread popularity of alternative therapies. These alternative therapies have been defined using a number of terms. Societies around the world have favoured the term *complementary and alternative medicine* (CAM) (Baer, 2008; Weir, 2005). This development in the provision of health care has led to the integration of a biomedical model of health care with that of a CAM model of health care. *Integrative medicine* has now become a new expression in Australian and international health care systems (Baer, 2008).

In answering the main research question "What is the professional status of Australian osteopathy?", the osteopathic profession exhibits features of a complementary health care provider within the health care system, as in the United Kingdom (UK). Osteopathic scope of practice is primarily conducted in private health care clinics (Cameron, 1998) focusing primarily on the management and treatment of musculoskeletal conditions. Unlike the American Osteopathic profession, which enjoys primary health care status accessing all sectors of health care provision, development and training opportunities (Cameron, 1998; Gallagher & Humphery, 2001; Ross-Lee & Weiser, 1994b). Australian osteopaths are recognized as providers of musculoskeletal health care by all private insurance companies and all government authorities. In Australia, physicians / medical practitioners act as gate keepers to the provision of osteopathic services that are government funded (such as Department of Veterans Affairs services and Enhanced Primary Care (ECP) plans). Australian osteopaths have access to hospital government funding, however no Australian hospital has employed osteopaths for the provision of health care services. In concluding, Australian osteopathy professes to having primary health care professional status with registration boards in each state and territory of Australia, tertiary educational training programs and independent self-determining professional associations. In the Australian health care system,

osteopathy has the professional status of a complementary and alternative health discipline (Baer, 2006; Weir, 2005).

The integration of osteopathy in health care systems around the world has undergone professionalization from a number of different approaches. From its beginning in the United States, as with all health care professions, osteopathy has been exposed to societal, government, educational and professional issues in its country of origin (Baer, 2004; O'Neill, 1994; Peterson, 2003). The history of the osteopathic professions internationally has been documented by authors who have followed the development of osteopathy in Australia (Cameron, 1998; Hawkins & O'Neill, 1990; Jamison, 1991; O'Neill, 1994), in the USA (Gallagher & Humphery, 2001; Gevitz, 2004; Patterson, 2001; Peterson, 2003; Ward, 2003), and from professional accounts of the profession in the UK (McKone, 2001). Government reports in Australia (Webb, 1977) also provide a societal perspective of Australian Osteopathy. These authors cite a number of strengths and weaknesses in the continual existence of the osteopathic discipline in Australia and internationally. This chapter summarises and identifies relevant issues relating to the professionalization of osteopathy and evaluates the effects of these issues on the profession (Ross-Lee & Weiser, 1994a). The main mechanism for advancement of a profession's status (professionalization) has been identified as a continuous cycle of quality assurance in addressing societal needs based on a biomedical and sociological model of health care. An understanding and commitment from within the profession is required, such as personnel, procedural frameworks and support structures within government, educational and health provider institutions (and authorities) based on guiding principles and mission statements that address the health care needs of society. Examples of these processes are found in the development of the medicine and other professions internationally, and Osteopathic profession of the USA and UK that have expanded and prospered. Government policies, societal influences, educational and professional issues are critical in professionalization of Australian Osteopathy. These issues may be considerable, yet not unmanageable, when rational and

logical processes of realignment are elucidated in collaboration with stakeholders within the Australian health care system.

3. What is meant by 'profession', 'professionalization' and 'professionalism'

The terms 'profession', 'professionalization' and 'professionalism' have been defined by a number of authors. Review of research publications reveals diverse definitions on professionalism. This thesis adopts a sociological approach to the development of professionalism. A number of sociologists have used sociological orientations relating to society as means to define these terms (Grbich, 2004; Newman, 2004).

Professions have developed within our society, and Australian Osteopathy is investigated in relation to what professional characteristics osteopaths possess within our society. Sociological orientations form the basis for investigating 'What are the professional characteristics of Australian osteopaths?'. Sociologists Karl Marx, Talbott Parsons, Eliot Freidson and Max Weber have been credited as key authors in the study of professionalism over the last century (Newman, 2004). Developed countries have developed order in the distribution and provision of health care services using the dynamic interaction of professionalization of a number of occupations with society. Professions have been conceptualised using a number of descriptions (Robbins & Barnwell, 1994). These descriptions allow the relationships between professions and society to be viewed using a number of 'lenses'. A number of different organizational and sociological orientations from key authors in sociology that pertain to health care professions (Grbich, 2004; Newman, 2004) and occupations include:

a) the ***conflict perspective*** in which society is viewed in terms of conflict and struggle between difference interest groups for power and control. Inequality and division between groups allows some groups to benefit at the expense of others (Newman, 2004). Order in society evolves as groups pursue dominance from the coercion of government and societal institutions to legitimate their influence and power towards benefits for a particular interest group.

   Karl Marx is a key author in this perspective, who argues that with limited resources in society, individuals and groups seek power and dominance over other members by establishing

organizations that influence society to serve their interests (Newman, 2004). Individuals and groups tend to be wealthy with access to economic, educational, and political systems to maintain their power and social order.

Feminism can be viewed as an extrapolation of this perspective. Sociologists relate the fact that women have possessed less power, influence and opportunity compared to their male counterparts, as women have traditionally been expected to engage in undertaking the majority of household and family responsibilities that are generally unpaid. Men have therefore been traditionally free to enter education, politics, career, and other social life that have a more direct influence on society in the form of power and control (Newman, 2004).

Michel Foucault, another key author in sociology, illustrates the historical development of knowledge and power by increasing surveillance and control using educational and health care (hospitals) institutions that were established pertaining to health care (Gabe et al., 2004). Within these institutions, knowledge relating to health, disease and illness is primarily generated to contribute to medicine. Underpinning of the medical model is maintained through the generation of scientific knowledge about the working of the human body, while excluding the other interest groups. Social shaping of this scientific knowledge within these institutions allows a relationship between it and the knowledge of, and understanding of, health and illness of lay people in society to occur (Gabe et al., 2004).

b) the ***structural-functionalist*** perspective where society is understood as an intricate and complex system consisting of co-ordinated parts, which each contribute to maintenance of harmony and equilibrium. Individuals and groups within this society are observed to share common interests and goals in maintaining the 'whole' of society. Social institutions work to meet the needs and 'fabric' of society by adapting to environmental changes and reducing tension between individuals and groups. 'Dysfunctional' aspects of social life disappear as they impede a society's survival.

Talcott Parsons is a key author within this perspective who has documented particular studies in regards illness behaviour and the 'sick-role' in relation to the doctor-patient relationship (Gabe et al., 2004), and negotiated order. Parson's model of the sick role is an 'ideal type', being characterized by abstract generalization and exaggeration of empirical reality (Gabe et al., 2004). The relationship between the patient and the doctor benefits both and is reciprocal and therefore unproblematic. When conflict in the relationship arises, this conflict evolves from doctors' ambivalent expectations of how patients ought to behave when they consult.

One of his Parson's legacies relate to his concept of gender roles; where men worked as 'bread winners', and women worked in terms of family roles (Gabe et al., 2004). These roles were associated with beneficial and adverse consequences to the health specific to each gender. Furthermore, Parson's functional perspective also identified how marital status affected health. Married men and women had better health than single men and women (Gabe et al., 2004). These observations evidence further the structural-functionalist perspective that in marriage, each co-ordinated part of the relationship contribute to maintenance of harmony and equilibrium in the 'whole'. This perspective incorporates ***collective impression management*** by Erving Goffman (Newman, 2004). Autonomous beings are highly dependent and constrained by one another, and possess trust and loyalty for each other. Boundaries exist between these beings in social environments such that together they act and demonstrate a common view and cohesion. The impression that is given is one of stability and power, as the performance of each being is successful in portraying teamwork to other people in society.

c) the ***symbolic interactionism*** perspective defines a society as being socially constructed and consisting of strong societal patterns and structures. Key authors in this perspective include Max Weber and Jurgen Habermas, who identify the production of consequences and outcomes from the interaction of people (Newman, 2004). Human behaviour of individuals or groups constantly attempts to interpret what people mean and are 'up to', not from an objective approach, but from a subjective approach related to the given situation they are in (Newman,

2004). Micro-level communication between individuals occurs that establishes social patterns and allows an individual to construct meaning in their social environment (Newman, 2004). These patterns run the risk of ignoring larger (macro-level) patterns that define social structures between potentially powerful individuals and groups, that remain in history, institutional and cultural settings.

In understanding professionalization as a sociological entity, an assimilation of the above perspectives is therefore needed, where at times one perspective complements the other, and at other times the above perspectives contradict each other.

Surveying and interviewing as data collection procedures allow the disarticulation of issues within the osteopathic profession to be undertaken. Data collection and analysis provides a basis for categorizing the professionalization of Australian osteopathy, within the scope of the abovementioned sociological perspectives. Assessing key informants' perception of Australian osteopathy compared to the profession as a whole, and identifying gaps in the Australian osteopathy professionalisation in sociological terms. Aspects of Australian osteopathic professionalism considered include:

a) specific interest groups within society, government and their authorities that affect power and control within and external to Australian osteopathy; gender, access to economic, educational and political systems, possession of esoteric and scientific knowledge are all issues that are investigated in Australian osteopathy

b) an alliance with individuals and groups within this society that share common interests and goals in maintaining a viable and efficient health care system - the existence of Australian osteopathic autonomy is dependent on trust and loyalty for other health care professions as both Australian osteopaths act and demonstrate a common view and cohesion with that of other health care professionals - stability and power are provided to health care professions as the success of teamwork and a profession is portrayed to society

c) Australian osteopath's awareness of how micro-level societal patterns and structures (namely communication with other health care professionals and government authorities) affect professionalism; micro-level societal patterns found in Australian osteopathic practice which provide meaning to practitioners may be having a profound influence on macro-level societal patterns between the profession and the society.

Friedson in his work prior to 1970 implicated a set of important characteristics for defining professionalism. Freidson (1970) shifted his focus from attributes of professions to the process of professionalization, based on a number of principles. This shift in focus represents current professional and organizational relationships that are required in the process of professionalization. The majority of occupations form professions and organizations in order to develop identities and cultures. These professions function to allow occupations to operate and deal with competitive societal environments. It is the understanding of these relationships that an occupation can manage the political struggle in dealing with conflicts in the social issues of professionalism (Taylor, 2007).

The professionalisation of Australian osteopathy therefore requires the investigation of the relationships, barriers and conflicts within and external to the profession. Undertaking of survey and interviewing of osteopaths allows the views of Australian osteopaths on the current and possible future professional issues to be clarified, such that gaps in current societal, professional and organizational relationships in the process of professionalization can be determined. Internal and external issues (for example, education and research) influencing the professional status of Australian Osteopathy can be segregated and researched using organizational and professional 'lenses' to establish 'gaps' that deal with competitive societal environments and the political struggles and conflicts encountered.

4. ***Professionalization of an occupation***

Professionalism as a concept has developed over the last 100 years. The terms professionalism, profession and professional are confusing as all occupations claim to be professional, yet no occupation is known to meet all ideal criteria for professionalism as defined by Talcott Parsons (1964) (cited in Bessant & Watts, 2007), and by Eliot Friedson (2001). Professions or guilds developed in 1930s to 1960s. Professionalization refers to this process where an occupation becomes recognized as a profession. Characteristics of a profession include an occupation's ability to regulate their work practices, demonstrate autonomy, achieve status and prestige in society, and have power to direct policymaking (Cameron, 1998; Gallagher & Humphery, 2001; Parsons, 1964).Reasons for the professionalization of occupations are related to meeting community needs such that individuals of an occupation have integrity, and are committed to their society.

Classical professions that have these characteristics are Divinity, Medicine and Law. Over the last 100 years, modern medicine has been seen as most successful in achieving the highest professional status in health care.

Australian osteopaths have also been in existence since the early 1900s, yet they have not achieved the same professional status to that of medical practitioners and other health care providers, like physiotherapists. A comparison between the status of Australian osteopathy and that of medicine allows gaps in Australian osteopathic professionalism to be identified.

Controversy still exists on the process of professionalization. Models and theories of professionalism used are simplified representations of reality, as irrelevant and potentially confusing features of that reality are devalued. Tones (1990) states that such models allow a focus on the most important issues (Tones, 1990). Models that are accurate and comprehensive analogues of reality, enable explanations and predictions to be made in relation to unknown aspects of those parts of our world. Aside from the above authors who identify a number of sociological orientations that relate to the concept of professionalism, Eliot Friedson documented his theory and model of

medical professionalism since the early 1970s. His text "Professionalism – The third logic" is an accumulation of his work in defining particular principles to the development of professionalism in medicine.

Freidson's model of professionalism identifies in sociological approaches for establishing, reporting and co-ordinating components in developing a profession. His model can be viewed as a set of interrelated and interdependent ***principles*** arranged in a manner that produce a unified whole and tied to changes in economic, political and ideological structures. Interrelationships are characterised by two diverse forces: differentiation and integration. Specialised functions within a profession and organization are differentiated. Similarly, professions can be characterized by using sociological perspectives that have been defined by authors like Friedson. Each approach and perspective defines particular specialised activities and principles that a profession is required to acknowledge in advancing and maintaining its professional status. At the same time, in order to maintain unity among the differentiated components and to form a complete whole, a reciprocal process of integration needs to be maintained. Using Freidson's sociological perspective, important insights into Australian osteopathy can be conceptualised into performing specialised and integrated activities that are guided by principles and mission statements in the development and advancement of professionalism.

Friedson's work is used as a framework for this thesis as it relates closely to professionalism in health care like that of osteopathy, and is based on a profession that has attained a high level of professional status, that of medicine (Freidson, 2001). Of all sociologists, Friedson followed the emergence of the medical profession and became the most prolific author in the study of medical professionalism. His publications have considered and argued other sociological perspectives to arrive to a number of principles for developing professionalism and defining professionalism within a profession.

The conceptual framework of this thesis is based on Eliot Freidson's (Freidson, 2001) six principles of professionalism. In brief, professions have:

1. abstract and specialized knowledge, based on formal education and interaction with colleagues.

2. practice autonomy in that their constituents can rely on their own judgment in selecting the relevant knowledge or the appropriate technique for dealing with a problem.

3. autonomy consisting of the right to self-regulation by having licensing, accreditation, and regulatory associations that set professional standards and that usually require members to adhere to a code of ethics as a form of public accountability.

4. authority, such that it constituents expect compliance with their directions and advice, which is based on mastery of the body of specialized knowledge and on their profession's autonomy.

5. altruism, where professionals go beyond self-interest to help a client, and enhance their knowledge used in the public interest, while adhering to a code of ethics.

6. constituents who are well-paid and have high status.

The use of Friedson's principles on professionalism as a lens in reviewing Australian osteopathy is applicable in this thesis as Australian osteopathy represents an entity in the health care community comparable to medicine, law, religion and other health care professions.

The models proposed by Friedson and other authors illustrate that three aspects underpin and form the basis of medical professionalization (White, 2004). Firstly, the medical professionalization models proposed are based on the conceptualization of disease as the occurrence of biological events independent of social factors. Secondly, abnormal health conditions are based on mechanical processes, where disease and dysfunction is the result of bacterial and viral infection that affects interdependent parts of body, independent of a person's psycho-sociology. Thirdly, disease and dysfunction producing abnormal health are treated and managed/investigated using scientific

means. The medical profession was instrumental in using this body of esoteric and specialised knowledge to provide important health services to the community. In claiming this body of knowledge as its own, medicine gained have power to organize and control their future and that of other health professions. Interconnected institutions of knowledge generation, utilization and control were developed by the medical profession. Some of these institutions included hospitals and educational faculties in colleges and universities. Stability and promotion of these institutions occurred with economic support and social organization from government. Occupational control of health care work was achieved by the medical profession (Freidson, 2001), as education provided the knowledge and training that allowed professionals (like medical practitioners) to have job opportunities and to assume positions of authority within organizations, government and the broader community.

In these positions, professionals become autonomous in that they can rely on their own judgment in selecting the relevant knowledge or the appropriate technique for dealing with a problem. In this instance, the problem for the medical profession was to maintain control and power of the health care system. From a functionalist sociologists point of view, autonomy by the medical profession was attained as an exchange with society that allowed the profession to maintain their own regulations and standards and in return provide expert service to society in the area of health care (Freidson, 2001). This implies that such an exchange is a continual process between a profession and society. Society normally would regulate such a process and restrict a profession's autonomy.

Medicine demonstrated a responsibility to protect and to enhance their knowledge and to use it in the public interest. Its practitioners had concern for others and made up a moral community where some degree of self-sacrifice existed, whereby professionals go beyond self-interest or personal comfort so that they can help a patient or client. However, the medical profession with esoteric knowledge in health care and doctors in positions of authority within organizations and government were given the right to self-regulation and expand their autonomy. Within organizations and government, members of the medical profession developed and administered licensing,

accreditation, and regulatory associations that set professional standards and that required members to adhere to a code of ethics as a form of public accountability (Freidson, 2001).

Medical practitioners in society achieved authority based on the mastery of the body of specialized knowledge and on their profession's autonomy, and their opinion/advice was accepted in all sectors of the health care system without argument. Society became compliant to their demands and needs for their existence. Their demands included being well paid and having high status in society, as professional people were seen to work for profit, while amateur people worked because of motivation (Freidson, 2001). Medical practitioners were typically seen to be members of the upper class, and became associated with upper class professions. From a functional sociologist perspective, pay and prestige served to ensure the continued attraction of the best and brightest people to professional careers while conflict sociologists believed that professionals used their monopolistic control to ensure that they are well-paid (Freidson, 2001).

Professions, other than medicine, did not defend themselves well against medicine's control of health care. These professions worked in different sectors, with different vested interests and attacked each other than recognizing shared arrangements. No principles were spelt out by these professions in organizing and supporting their work and responsibility (Freidson, 2001). The medical profession also used a loose alliance with other professions to promote its professional interests, and further improve their scientific credibility in controlling the health care system. Pharmacy is one such profession that advanced the professionalization of medicine by promoting and maintaining social and political interests of doctors (Gabe et al., 2004).

Friedson also illustrates that in the process of professionalization, specialization occurred in medicine as part of a co-ordinated plan to transfer of knowledge to expert domains within the health care system. These expert domains included biomedical knowledge in pediatrics, surgery, pharamacology, gyneacology and orthopedics. This specialised work of the medical profession became even more inaccessible to other professions as other professions lacked knowledge, training

and experience in these domains. This form of specialised training is known as *discretionary* specialization, and is contrary to *mechanical* specialization that involves knowledge and skills for everyday living (Freidson, 2001).

Costello (2006) presents an analysis of obstetric professionalization and medicalization. The medical profession is shown to focus on the science of teratology in obstetrics. Marketing of obstetric teratology as a science was promoted through publication (Costello, 2006). Costello (2006) contests the evidence of the science. Costello (2006) states that the evidence was inaccurate and 'cloaked', as health care outcomes were not discussed and professional claims were bound to male professional identities that convinced other male medical practitioners (Costello, 2006) of their superior skill and knowledge in obstetrics. Under-reporting and over-reporting (Costello, 2006) of obstetric conditions in publications assisted these obstetricians in achieving professional goals by using the honour of publication to entice medical practitioners and public to defer obstetric authority to medical obstetricians rather than any health care profession. The impression given by obstetricians to society was that a focus on the science of abnormalities in pregnancy and child birth would be able to prevent, diagnose and cure disease. The progress of science in this domain formed a significant part of medical ideology, and served the purpose of establishing obstetrics as a profession.

The medicalizing of childbirth by the medical profession served to allow obstetricians to define a problem and to control access to solutions through superior and abstract knowledge and medical science (Costello, 2006). Gender politics in the field of obstetrics prevailed as the medical profession with its prestigious and well-renumerated obstetricians were primarily of male gender whose practice focussed on the highly respected science of medicine. Midwives were primarily of female gender and expected to be more caring than male obstetricians with the less valued technical knowledge (Costello, 2006).

Outcomes from obstetric care provided by obstetricians and midwifery were never contested and competition between the two occupations eventuated. Midwifery became allied to medicine as competition increased even with government legislation (Costello 2006). Obstetricians demonstrating alturism by volunteering to work in hospitals and aligned themselves with general practitioners (private practice). The resulting competition between the two occupations occurred when obstetricians launched a joint effort with medical practitioners against midwives, segregated themselves from the term 'midwife', when gender relationships developed within the obstetric health care provision, and by affiliating themselves with hospitals. Politics prevailed as obstetricians mobilized to increase number of births in hospitals and less in community, when risks and deaths in hospitals were increasing (Costello 2006). At this stage, it becomes apparent that medical profession had been effective in convincing the regulators that medicalization of obstetrics was should be promoted, even when this went against evidence (Costello 2006)

Though, Freidson (2001) states that 'we should not lose sight of the fact that professions are not defined on the basis of a checklist based on these characteristics, but as the result of a process of social definition. Ultimately, clients, members of related professions, and the broader society determine whether an occupation achieves and retains professional status. Professionalization is always contested and even once the contest has been won, the process remains dynamic.' A review of changes in health care systems over the past 60 years illustrates how medical professions internationally are being deprofessionalised (Freidson, 2001).

One of the reasons for medicine's deprofessionalisation relates to the existence of 'lay' knowledge within society. Lay knowledge refers to people's beliefs about illness and health care that are representations of culture and society (Gabe et al., 2004; Popay et al., 1998). Lay knowledge is not 'residual', but complex bodies of knowledge and contextualised rationality that are central to the understanding of culture and society (Gabe et al., 2004). This knowledge contains empirical approaches to everyday life and situates personal experiences in relation to broader frameworks of existence in society (Gabe et al., 2004). While empirical approaches to sociological dilemmas and

events are supported by evidence and biomedicine in health care, lay knowledge addresses these events by providing interpretations that are not supported by evidence and bioscience (Gabe et al., 2004); lay knowledge brings about an integrative and holistic approach to health care.

When properly used, this type of knowledge allows for a rational approach to health provision to be undertaken, that prevents the clash of perspectives (Gabe et al., 2004). The effect on a health care system is profound by allowing complementary and alternative therapies to exist in a society where the biomedical model of health care dominates. Society adopts processes for validating and utilizing the strengths of complementary and alternative therapies within the health care system. Evidence is sought through research undertaken by government, consumer groups, educational institutions and health professionals to integrate these therapies into society's health care system (Grbich, 2004).

Research methods used in answering research questions in this thesis allows the researcher to collect and analyse data by compartmentalising the data in relation to Freidson's principles of professionalization. Analysing data collected is undertaken to identify the current professional status of Australian and the existence of any gaps (if any) in Australian Osteopathic professionalization. By surveying Australian osteopaths and interviewing key informants abstract and specialized knowledge that exists in osteopathic practice can be contextualised, and identifying how osteopaths interact with colleagues and other health care professionals in generating this knowledge. Furthermore, surveying osteopaths and interviewing key informants can determine to what extent osteopaths exert autonomy in practice and the broader community, and how effective this autonomy is in allowing the osteopathic profession to undertake self-regulation. An analysis of the data allows the research an opportunity to investigate the extent of specialized knowledge generation and related research being undertaken to give the profession recognition as an authority in health care, particularly in the management of musculoskeletal conditions.

5. How does grey literature relate to defining osteopathy as a profession internationally and in Australia – using a broad perspective

Osteopathy is recognised internationally in all continents of the world (British Osteopathic Association, 2008; Osteopathic International Alliance, 2006). Its reputation as a health care profession in each country varies from that of a fully recognised system of orthodox health care to that of *complementary* and *alternative medicine* (CAM)(Baer, 2006; Weir, 2005). *Alternative* medicine is known as a health care discipline "that does not fall within the realm of conventional medicine." Commonly cited examples include naturopathy and naturopathic medicine, chiropractic, herbalism, traditional Chinese medicine, Ayurveda, meditation, yoga, biofeedback, hypnosis, bodywork, homeopathy and diet-based therapies. *Complementary* medicine refers to interventions used in conjunction with mainstream medical techniques. Alternative medicine practices are as diverse incorporating or basing themselves on traditional medicine, folk knowledge, spiritual beliefs, or newly conceived approaches to healing. In some countries, alternative medical practices may regulated by government. The practice of alternative medicine practitioners is generally not accepted by the medical community because of the lack of evidence documenting the safety and efficacy of alternative medicine. When the safety and effectiveness of an alternative medical approach or therapy has been established, it may be adopted by conventional medical practitioners.Comparing osteopathic professions internationally, American osteopathy demonstrated the highest degree of professionalism and is a major provider of orthodox health care (American Academy of Osteopathy, 2003; American Osteopathic Association, 2007; Baer, 2004, 2006; Gallagher & Humphery, 2001; Gevitz, 2004; Patterson, 2001; Peterson, 2003)

Gray literature (California State University Library, 2008; University of New England Library, 2008; Weintraub, 2000) provides succinct historical accounts of major events that have influenced the development of osteopathy in the USA, UK and Australia. Government reviews and commentaries by osteopaths that primarily make up the gray literature describe the development of osteopathic educational programs, legislation and scope of practice in each of these countries (Baer,

2004; Cameron, 1998; Gallagher & Humphery, 2001; Hawkins & O'Neill, 1990; Peterson, 2003; Webb, 1977). Common to all of the gray literature is a lack of comment and analysis in regards to the professionalization of the discipline in each country. Particularly, there is a lack of delineation and identification of sociological processes that affected the professionalization of the osteopathic discipline. Further research and inquiry that forms the basis of this thesis provides a basis for answering the research question "What is the current professional status of Australian Osteopathy?"

6. Professionalization of Osteopathy in the United States, United Kingdom and Australia *- a historical analysis & setting the scene*

Publications relating to the Australian osteopathic professionalism are scarce. As stated above, gray literature exists that has not been investigated in a formal process to elucidate professionalization of Australian osteopathy. Evidence has not been established to document the existence of Australian osteopathy as a profession. Sociological perspectives and Freidson's principles on the development of professionalism are used as a 'lens' to examine osteopathy in Australia, America and Britain. For the advancement of osteopathy in Australia, an assessment of the osteopathy's development in America and Britain is undertakenas anecdotally these professions have a higher professional status to that found in Australia.

Professionalization of American Osteopathy

American Osteopathy was founded as a health care discipline in the early nineteenth century when many groups of healers existed that were neither well established nor well organized. In the post-civil war period, no licensing boards and few scattered state laws governing medical and health care practice existed (Peterson, 2003). There was great diversity in the healing professions, and while medicine acted as a major provider of health care in USA, it lagged behind developments in Europe. Gallagher and Humphery indicate that physician training across the USA lacked consistency and quality overall, and a unified definition of practice did not exist (Gallagher & Humphery, 2001). Physicians were struggling to make a livelihood. Medicine was divided, with guilds arguing and bickering between themselves in relation to their different origins, education and ideas on pharmacological and surgical treatment (Gallagher & Humphery, 2001; Gevitz, 2004).

With medical licensing and regulatory agencies in a splintered state, medical training was primarily based on a guild system (apprenticeship approach). As the medical fraternity in the USA was establishing itself, osteopaths, allopaths and homeopaths were also seeking recognition as health care disciplines (Gevitz, 2004; Peterson, 2003). Professional groups competed with each other,

resulting in conflict in regard to what should constitute their respective domains and scopes of practice (Gevitz, 2004). Eventually, in 1847, the American Medical Association (AmMA) was founded and standards of medical education were established in 1903 (Peterson, 2003). The AmMA and its affiliate societies then began to strongly lobby the state regulatory boards to support the association in the advancement of its professional status. The AmMA became more stable, successfully asserting the medical profession as the primary provider and arbitrator of health care in the community. Complementary and alternative health care approaches, that included osteopathy, that were not accepted by the AmMA, found it difficult to establish themselves in the short and long term.

Osteopathy as a health care system and discipline was founded by Andrew Taylor Still in 1889 (Still, 1892). Around 1864, Still watched as the therapies of his medical colleagues failed, and three of his family died to meningitis. This incident was the precursor to the founding of the osteopathic discipline. Still endeavoured to develop a discipline that was to address health care where medicine had been unsuccessful. He was a medically trained practitioner to all intents and purposes, which included medical apprenticeship training from his father and his self-directed learning in anatomy, physiology, surgery and *materia medica* (Baer, 2008; Gallagher & Humphery, 2001; Gevitz, 2004; Peterson, 2003). In Kirksville, Missouri, Still practiced his style of health care using manipulative/manual medicine and physical therapies, while condoning the use of heroic therapies (Gallagher & Humphery, 2001). His physician colleagues criticised and distanced themselves from him. Still's practice did not flourish until he successfully treated a number of prominent people of the community, who had unsuccessful medical treatment for their conditions from other physicians (Gallagher & Humphery, 2001). These prominent individuals eventually became sponsors for Still's style of health care practice, and the American osteopathic profession. By 1889, Still's reputation as a healer had spread, his health care system was much sought after and eventually he established a school to teach and train others.

Hawkins and O'Neill claim the concept that the osteopathic discipline was institutionalized and secured with the establishment of the American School of Osteopathy (ASO) in May 1892 (Peterson, 2003). The ASO increased the popularity of Osteopathy throughout the USA, and a number of self funded training institutions were established (Peterson, 2003). The professionalization of osteopathy continued, as the ASO developed esoteric and specialized knowledge for osteopathic practice.

With the increasing popularity of Osteopathy and the establishment of the ASO, in 1893, the medical fraternity in Missouri endeavoured to legislate that those practicing osteopathy should be graduates of a reputable medical school (Gevitz, 2004). Following a number of legal challenges by the medical fraternity and vigorous opposition from a number of osteopathic patients, sponsors, and profession, a separate osteopathic bill was proposed. This bill was vetoed by the Missouri governor, Governor William Stone, on the basis that osteopaths were insufficiently educated. Initially this event seemed to have been disadvantageous to the developing osteopathic profession. Between 1893 and 1896, the ASO realigned its training curriculum to be consistent with that of a standard medical teaching program, with the exclusion of *material medica* in the curriculum. From a sociological perspective, the ASO's and the osteopathic profession's quality control mechanisms realigned their education to address the needs of society and government. In 1897, with Stone no longer the governor of Missouri, and his successor, an osteopathic patient, the Osteopathic bill was proclaimed into law. This law allowed the ASO to expand and prosper, as its teaching faculty grew, with the assistance and inclusion of new academics from law, political science, chemistry, medicine and surgery faculties (Gevitz, 2004). Academics, in developing esoteric and specialized knowledge at the ASO, sided and collaborated with specific interest groups within society and government that had power and control. These special interest groups advised academics at the ASO on curriculum and knowledge required to meet the health needs of society. The advancement of the professional status of American osteopathy resulted from an awareness of how micro-level societal patterns and structures (namely communication with other health care professionals and government authorities)

These micro-level societal patterns had a profound influence on macro-level societal patterns between the profession and the society (Freidson, 2001; Newman, 2004).

The societal patterns that promoted the professionalization of American Osteopathy was also dependent on the diversity in profile of the ASO staff and students. Gevitz describes how the ASO accepted students that included migrants, females and indigenous black people in higher proportion than that of medicine (Gevitz, 2004). Altruism prevailed as a professional trait at the ASO, as a large number of these students were taught osteopathy by waiving fees. Hawkins and O'Neill provide evidence of the ASO advertising that 'the school is open to students of both sexes without distinction, and all have equal opportunities and privileges, and are held to the same requirements' (Hawkins & O'Neill, 1990). This initiative provided opportunities for all groups of people in the community to reach higher levels of self-development and critical judgement. These attributes provided the students with mental habits, and the ability to grasp basic laws and principles that could be applied to any particular situation. Knowledge provided empowered the ASO graduates and provided them with the abilities to deal with societal demands place on their practice and the profession. These ASO graduates inherently acquired leadership attributes for the field of osteopathy in the USA. Graduating osteopathic practitioners met the needs of the lower socio-economic populations, who were in great need of health care. Upper class populations who had sponsored the ASO and who could afford to study osteopathy at the ASO, were also provided with proficient osteopathic practitioners. All populations of the USA were able to access osteopathic health care. The graduates from the ASO were therefore able to meet the demands of their immediate community and personal needs, and subsequently the needs of an expanding profession as leaders (Hawkins & O'Neill, 1990). The social implications on the professionalization of the osteopathic profession were vast as the broad characteristics of graduates minimised gender and socio-economic barriers and improved access to societal economic, educational and political systems. Altruism in American osteopathy prevailed as the discipline provided health in the public interest to all persons of the community.

Between 1897 and 1901, the American Osteopathic Association (AmOA) was formed by the alumni of the ASO and a number of other osteopathic schools. The executive of the AmOA consisted of dedicated and motivated osteopaths with leadership and management skills for the advancement of its professional status (Peterson, 2003). In 1901, the Committee on Legislation within the AmOA devised a standard model bill for every state of the USA. The bill's prime objective was to create independent boards for the examination and registration of osteopathic graduates, and eventually the accreditation of osteopathic institutions (Gevitz, 2004). The values and powers of critical judgement and the imaginative insight of osteopathic graduates on this AmOA Committee provided leadership for the profession. These representatives were able to convince the government that members of medical profession on Osteopathic boards discriminated against the direction of osteopathic profession. The osteopathic profession won a considerable degree of autonomy and legal security as a professional entity from the work of AmOA representatives (Gevitz, 2004). By 1903, the AmOA had formed the Council on Medical Education. This council adopted standards for the approval of osteopathic training institutions. Consequently, the effect was the demise or merger of a number of osteopathic institutions. This Council provided an informed, consensus and united view of an Osteopathic curriculum to meet the needs of the training institution, community and profession. As the AmOA evolved, the membership of its committees and councils continued to educate themselves and expound highly specialized knowledge and action plans in response to their environmental demands and constraints. Policies were developed that provided a framework for the continual re-assessment of the profession, self-regulation, and the education of its practitioners.

In 1904 the AmMA formed its own Council on Medical Education, which also adopted standards for the approval of medical training institutions that also led to the demise or merger of a number of medical and osteopathic training institutions (Peterson, 2003). The AmMA inspected and surveyed medical training institutions, accrediting those institutions with appropriate standards. Often the accredited institutions that were affiliated with universities had included science faculties and stable

funding. Surveying of osteopathic training institutions was not undertaken by the AmMA, and the AmOA placed itself in a privileged position, similar to that of the AmMA. In a similar way to the accreditation of medical training institutions by the AmMA, the AmOA accredited osteopathic training institutions, maintaining control and developing its future educational needs, institutions and scope of practice.

In 1910, the Carnegie Foundation for the Advancement of Teaching in America and Canada commissioned Abraham Flexner to chair a review of medical education in America and Canada. The *Flexner* report was highly critical of the osteopathic training institutions (Flexner, 1910). The terms of reference of this report are not clearly defined, however the report stressed the importance of training for all health disciplines by stating,

'In making this study the schools of all medical sects have been included. It is clear that so long as a man is to practice medicine, the public is equally concerned in his right preparation for that profession, whatever he call himself, - allopath, homeopath, eclectic, osteopath or what not. It is equally clear that he should be grounded in the fundamental sciences upon which medicine rests, whether he practices under one name or under another.'(Flexner, 1910)

A number of recommendations arose from the Flexner report, which were adopted over the next twenty five years by the AmMA (Flexner, 1910). The recommendations included that:

a) commercial and weak schools with poor medical education be closed down

b) each surviving medical college become a integral component of a major university, thus ensuring higher academic standards

c) hospital establishments be funded to support clinical teaching

d) the funding of medical colleges be altered.

The inclusion of eight osteopathic training institutions in the Flexner report was not guaranteed. The impetus behind the inclusion of eight osteopathic training institutions in the Flexner report arose from another sponsor of the osteopathic discipline, Henry Pritchett. Henry Pritchett was the head of the Carnegie Foundation and had experienced osteopathic treatment (Gevitz, 2004). Flexner supported Pritchett in his view to review osteopathic institutions, as Flexner claimed that osteopathy was a complete health care system. Flexner also placed the osteopathic profession on an equal footing to medicine by stating that,

'... the osteopath needs to be trained to recognize disease and to differentiate one disease from another as carefully as any other medical practitioner.' (Flexner, 1910)

Flexner then reported that,

'... no one of the eight osteopathic schools is in a position to give such training as osteopathy itself demands.' (Flexner, 1910)

With the unfavourable comments and outcomes of the Flexner report towards the osteopathic training institutions, resentment arose within the AmOA Board of Trustees and accredited training institutions. This was because the AmOA Board of Trustees and accredited training institutions felt that educational reform for the osteopathic profession would be challenging (Gevitz, 2004), though the AmOA Committee on Education agreed substantially with the Flexner report (Gevitz, 2004). Further debate and disagreement in the AmOA, between the Board of Trustees, the accredited training institutions and the Committee on Education resulted.

The AmOA and osteopathic training institutions failed to embrace the recommendations in the Flexner report. However the medical fraternity adopted the Flexner report recommendations. This resulted in the medical profession expanding and consolidating its position as the primary health care provider and to accessing funding through taxes, public and private general university funds, and philanthropy (Gevitz, 2004). The American osteopathic profession withered in the interim.

The critical Flexner report recommendations were addressed years later by American osteopathic educational institutions from a defensive position, as they struggled to establish their credibility as providers of quality health care education. In the late 1920s, with an emphasis on improving the osteopathic education standards and the eventual inclusion of obstetrics, pharmacy, and surgery into its curricula, American osteopathy moved towards expanded practice rights (Patterson, 2001). The American osteopathic educational institutions integrated specialist health care, research and science knowledge into the educational frameworks, responding to the demands of the government and population. The need for adequately trained health professionals was high, particularly after World War II. The integration of general practice and specialist skills into osteopathic education enabled osteopaths to be considered as equivalent to medical practitioners. Osteopaths undertook primary health care roles and responsibilities with the gradual expansion of their practice rights. The osteopathic profession was subsequently able to enjoy professional health care status and opportunities similar to those provided to the medical profession. The professional status of osteopathy escalated with access to all health care sectors, collaboration in health care policy development, and the provision of government funding for osteopathic research, educational and health care institutions. Sociological processes that transpired included alliances with individuals and groups within this society that share common interests and goals in maintaining a viable and efficient health care system. American osteopathic autonomy developed and was dependent on trust and loyalty for other health care professions that demonstrated a common view and cohesion with that of other health care professional. Stability and power was constructed from successful teamwork portrayed to society. On accepting changes recommended by Flexner report, professionalization of American osteopathy continued.

The osteopathic profession had unconsciously built a continual process of quality assurance. The AmOA challenged their own discipline and position in American health care provision. Criticism from government regulators and the medical profession led to informed and motivated osteopathic leaders establishing procedural frameworks and support structures to challenge the government and

medical criticism and to prosper in a competitive environment. AmOA lobby groups set an agenda to discredit the medical profession's dominance, to target and force government into providing laws for the acceptance of the osteopathic profession. Government accepted osteopathy's scope of practice, provided funding for research, education and health care facilities, and remunerated osteopathic services through government health care departments and private health insurance funds (Peterson, 2003).

Speciality health care training was adopted into osteopathic curricula to meet demand and to facilitate research in these specialities. Hospitals and health care training facilities were provided to facilitate for the integration and collaboration of the discipline of osteopathy with main stream health care. Research institutes were established (Peterson, 2003), which facilitated the production of influential osteopathic research for professional credibility and identity. In summary, the strategic planning and quality assurance processes required and adopted by the AmOA, included the development of a professional association, educational and health care institutions, research councils and lobbying groups. Through collaboration and segregation of these professional and educational entities and activities, the osteopathic profession was protected in its continual growth.

The development of American osteopathy illustrates how sociological processes were apparent in its professionalization. American osteopathic education began with Still in 1897 who not only founded osteopathy, but also established the ASO. A small number of osteopathic educational training institutions had been established by the 1910s. Esoteric and specialized knowledge was created through a process of quality assurance that entailed informal communication between their graduates and the academic staff in developing osteopathic curricula. In the 1920s, recognition of osteopathy as a health care professional occurred with the AmOA instituting policies, accreditation and registration procedures. Autonomy and self-regulation professionalised American osteopathy. Service markets became diversified in a complex and elaborated organisational structures of

society. Growth opportunities and decision making processes related to professionalization have involved decentralisation of professional organizational processes as informed, experienced and qualified individuals representing American osteopathy have permeated into all areas of health care policy development and management.

Today, American Osteopathy's composition consists of 60,000 osteopaths, twenty-three well-developed educational programs, and a broad scope of practice in all speciality areas of medicine. Osteopathic registration boards and informed osteopaths exist in the states of the USA, which in collaboration with academic and research support from universities, maintain and advance professionalism in American osteopathy.

Analysis of the current status of American Osteopathy using a sociological perspective reveals that with respect to abstract and specialized knowledge, it is composed knowledge based on science and art in all areas of health care practice. Osteopathic university programs are used as a framework for this knowledge and its development (or advancement) in osteopathic practice. This is supported by a large number of associations, academies, insurance companies and research foundations/establishments (American Osteopathic Information Association, 2008; Oklahoma Osteopathic Association, 2008). The use of propositional and non-propositional knowledge in American Osteopathy is governed by processes of self regulation and accreditation founded in legislation of all USA states. Autonomy is the outcome of such processes; as the type and amount of professional knowledge required in osteopathic health care and its specialist areas is governed and regulated by the profession itself.

The development of abstract and specialized knowledge, autonomy, self-regulation and accreditation processes within American society and the osteopathic profession have engendered a mastery of specialized knowledge and autonomy in all areas of American osteopathy practice. Mastery of specialized knowledge and autonomy have been segregated into colleges of the

osteopathic profession representing particular specialist areas of health care (like pediatrics, obstetrics, orthopedics and general practice).

Sociologists, like Friedson, states that the status of a profession is defined by the type and amount of remuneration attained by its members. Members of a profession are privileged to financial returns consistent with their mastery of knowledge and skills that a community has a need for. American Osteopathic practitioners are one of the most highly paid professionals in the USA (US Department of Labor - Bureau of Labor Statistics, 2006).

Professionalization of British Osteopathy

In 19th century complementary therapies were acceptable forms of health care in the UK. Lay knowledge in health care existed from the time of ancient Greece. European health care had developed a number of therapies and groups of healers in society, which were viewed as being effective and acceptable. Osteopathy in Europe, and particularly the UK, was entering a society with liberal views on the provision of health care. In the 19th century the European medical fraternity was able to distance itself from these therapies and healers, however they continued to survive. In ancient Greece, manual therapy was used to treat a wide range of ailments and was later adopted by the Romans (Gevitz, 2004). French, German, and Scandinavian physicians promoted the use of manual therapy in their scope of practice (Gevitz, 2004). Peter Henry Ling (1776-1839) further popularized his manual therapy approach known as 'Swedish Movements'. Initially this manual therapy was dismissed by the Swedish medical community, but later accepted as this manual therapy. Acceptance of this manual therapy resulted from successful outcomes in cases where medication was unsuccessful, and after the publication of hundreds of articles and books on this approach (Gevitz, 2004). The acceptance of successful outcomes of manual therapy that were established as lay knowledge in European society, allowed disciplines like Osteopathy to establish themselves in the area of manual therapy. The launch of Homeopathy in Germany by Samuel Hahnemann (1755-1843), also prospered throughout Europe. This discipline was also integrated by

a number of early American doctors into their scope of practice (Gevitz, 2004). In summary, from these early times, the European health care scene accepted complementary and alternative forms of health care, and osteopathy in the UK was founded in parallel with firm societal views and lay knowledge that acknowledged the success of complementary and alternative disciplines.

The beginning of the 19th century was a fertile period of time for osteopathy to develop as a distinct profession in the UK. In 20th century, the first osteopathic college was established in the UK by a Scotsman, John Martin Littlejohn, who had studied under Dr Andrew Taylor Still at the ASO in the USA. Littlejohn's curriculum vitae included receiving a MA degree in classical languages, being ordained as a priest, obtaining a first class degree in legal science, the William Hunter Gold Medal for Forensic Medicine, and a PhD degree (McKone, 2001). Littlejohn founded the British School of Osteopathy (BSO), the first osteopathic education institution outside the USA. This event signified the start of the professionalization of British Osteopathy, with the institutionalization of esoteric and specialized knowledge that formed the foundation of osteopathic practice. At this school, British osteopaths were taught the use of manipulative techniques based on the Still's principles and philosophy, but were not accepted as medical doctors. Other osteopathic schools were founded subsequently. The London College of Osteopathic Medicine (LCOM) founded in 1927, became a prominent osteopathic training establishment in pursuit of an American curriculum and recognition as medical practitioners. When LCOM's endeavours to be recognised as medical practitioners became unsuccessful, its curriculum became an avenue for British physicians to supplement their medical training with an osteopathic education (McKone, 2001; Webb, 1977). Unlike the situation in the USA, animosity between the medical fraternity and the osteopathic profession failed to eventuate. Animosity did not eventuate because the LCOM and the other British osteopathic training institutions provided the osteopathic profession with respect and integrity. Whether the American medical profession's failure to control the osteopathic profession affected the British medical fraternity's behaviour in avoiding confrontation with the British osteopathic profession is

unknown. The result for the British Osteopathic profession was attaining independence as a distinct and complementary health care profession.

Further recognition of the British osteopathic profession was slow. Laws governing the registration of osteopaths and scope of practice were not enacted until the professional status of osteopathy had increased. The profession not only included powerful people in strong social structures, including John Martin Littlejohn, but also provided osteopathic treatment to and was sponsored by potentially powerful people. These people included the British Royal family, George Bernard Shaw, and athletes and members of sports and Olympic committees of Nazi Germany (McKone, 2001; The Prince of Wales, 2008). The Profumo Affair also illustrated the close affiliation of osteopathy with influential and powerful people in the UK (Metcalfe, 2008). This sociological perspective is described as a major influence in the professionalisation of an occupation by Max Weber (Grbich, 2004).

Apart from the influence of powerful community sponsors, osteopathy's professional status increased owing to raising of educational standards, and raising popularity and recognition in the primary health care departments, the National Health System (NHS) and with the private health insurers accepting and remunerating osteopathic service providers. The British osteopathic profession developed the General Council for Registered Osteopaths (GCRO). This Council registered osteopaths who had trained at reputable privately-funded and charity osteopathic educational institutions recognised by the NHS and private health insurers. Government received proposals from the GCRO and representatives of the osteopathic profession to register osteopaths from reputable establishments with high educational standards. This strategy would also force fledgling osteopathic institutions to improve their education or fade away. In increasing and regulating esoteric and specialized knowledge that formed the foundation of osteopathic practice, the profession had tailored (or realigned) itself to meet the needs of society and government, and self-regulated the scope of osteopathic practice.

Statutory regulation of Osteopathy occurred with the passing of the Osteopathy Act in 1993. In the Act, there was provision for the formation of a professional self-regulatory body, the General Osteopathic Council (GOsC), which was formed from the GCRO. The Act established its purpose as regulating the profession, by protecting the public through maintaining a practitioner register, by investigating allegations of professional misconduct, and by ensuring the quality of training, by accrediting osteopathic institutions that met particular standards. The Osteopathy Act (1993) provided the British osteopathic profession with recognition as a health care profession. It further increased the popularity and growth of osteopathy in public health, and osteopathic educational programs were established in government funded tertiary education institutions. The Osteopathy Act allowed government health care policy to accept osteopaths in health care research. One such example is a collaborative research project documenting the effectiveness of osteopathy in back pain (UK Back pain Exercise And Manipulation (UK BEAM) Trial Team, 2003). Currently seven approved British osteopathic training institutions have been established, and approximately 5000 registered British osteopaths exist. British osteopathy is a small but growing profession, when compared to the existence of approximately 36,000 physiotherapists in the United Kingdom. Within the European Union (EU) there is no standardized training or regulatory framework for the osteopathic profession, although attempts are being made to coordinate the profession within the EU. At present there is a conflict between the principle of free movement of labour and right to practice osteopathy in different member states. Little equivalency in training and regulation of the profession exists. Previously the practice of spinal manipulation by non-medically qualified practitioners was outlawed in many European countries. In the 1960s, a French osteopathic faculty was arrested and imprisoned. On their release, the French osteopaths sought refuge in the UK and established the European School of Osteopathy (McKone, 2001). Recently, the GOsC issued a position paper on pan-European regulation of the profession (European Public Health Alliance, 2005), which aims to maintain osteopathy's status as a health care provider in the Britain, France

and Switzerland. These countries wish to defend the practice and concept of osteopathy in the EU, as other EU countries initiate osteopathic schools, where the quality of training may not meet particular standards.

Today, British Osteopathy, although differing with American Osteopathy, still exhibits advancement in professionalism (Baer, 2004, 2006; British Osteopathic Association, 2008; European Public Health Alliance, 2005; Hawkins & O'Neill, 1990; House of Commons, 2001; McKone, 2001; O'Neill, 1994; UK Back pain Exercise And Manipulation (UK BEAM) Trial Team, 2003). In Britain, well-informed osteopathic leaders in research and education collaborate with universities, government and health care bodies. Efficiency in the use of informed, experienced and qualified individuals that represent osteopathy is increasing. Decision makers and managers are being confirmed as they acquire control. Enough osteopaths and educational institutions exist such that British osteopathic education organisations do not rely on a limited number of individuals or institutions. Clarification of management roles has occurred and has allowed policy development. Members of the British osteopathic education organizational structure who are not informed and qualified in supporting policy and may depart, do not to present a severe threat to organizational stability.

The scope of practice is primarily in manual medicine, though diverse in providing health care in all areas (including hospitals and within the NHS – National Health System), and is well placed to expand osteopathic practice and research opportunities to advance osteopathic professionalism. The current status of British Osteopathy is progressive in that it is developing abstract and specialized knowledge, incorporating a mastery of knowledge based on science and in the art of musculoskeletal health care. Mastery of specialized knowledge and autonomy have been segregated into particular specialist areas of health care in the UK osteopathic profession (particularly pediatrics, obstetrics, sports medicine and hospital rehabilitation and general practice) and are being supported by research. This sociological event is stimulating professionalization of British osteopathy by making it an authority in the health care of the community.

British osteopathic professional entry programs are based in private institutions, universities or affiliated with universities and a medical program. This framework provides osteopathic programs with credibility and access to knowledge and research sources for the development (or advancement) in osteopathic practice. The profession is supported primarily by two associations, insurance companies, the National Health Scheme (NHS) and research foundations/establishments (Baer, 2004). Processes of self regulation and accreditation are by the fact that the profession has representatives in the accrediting authorities (The Quality Assurance Agency for Higher Education, 2007) and in 1993 British legislation was established in the House of Commons regulating the practice of UK osteopathy. British Osteopathy is endeavouring to govern and regulate the profession through these processes and is establishing autonomy in its future direction.

Professionalization of Australian Osteopathy

Osteopathy arrived in Australia in the late 1880s from England and the United States. In this period of history, very few occupations were recognised as professions. Australian osteopaths were small in number and isolated from each other, as health care providers, these osteopaths did not belong to a profession. Other health care practitioners were more considerable in numbers and began forming guilds, colleges and associations. These health care practitioners began to form professions. Professionalization of Australian osteopathy differs when compared to the development of osteopathy in USA and UK (Baer, 2004; Baer, 2006; Cameron, 1998; Hawkins & O'Neill, 1990; Jamison, 1991a; O'Neill, 1994; Oths & Hinojosa, 2004; Webb, 1977).

In 1909, the first osteopaths arrived in Australia from the USA. These osteopaths assumed that they would develop a profession with similar characteristics to those of their American counterparts. However, in 1910 when the Flexner report was produced in the USA, there were only five osteopaths in Victoria, and even fewer around Australia (Hawkins & O'Neill, 1990). Compared to the American Osteopathic profession, the Australian Osteopathic profession consisted of few practitioners capable of developing a proactive profession. There were no Australian osteopathic training institutions, and any osteopathic training that was undertaken used a guild system approach (Hawkins & O'Neill, 1990). Compared to the American scene, the Australian Osteopathic profession was in its infancy, and grew slowly.

Osteopathy in Australia endured the adversity that the profession sustained in the USA. History has revealed continual opposition from the medical profession to accept osteopaths as primary health care professionals. Hawkins and O'Neill claim that opposition by the medical profession towards osteopathy has inhibited the development of the Australian osteopathic profession (Hawkins & O'Neill, 1990). Evidence of the Australian medical profession's opposition was apparent as early as 1927, when three Australian Osteopaths accused by the Australian medical profession of calling themselves doctors. The Victorian Supreme Court convicted these osteopaths for practicing

medicine illegally, even though they were trained in USA at the ASO and claimed to be Doctors of Osteopathy. The Victorian Supreme Court's verdict defined the scope of Australian osteopathic practice limiting it to the diagnosis, management and treatment of musculoskeletal conditions (Hawkins & O'Neill, 1990). In this manner, the Australian medical profession was instrumental in preventing osteopaths diagnosing, managing and treating all health care conditions that affected members of the community. The Australian Osteopathic profession had no autonomy in self-regulating its scope of practice and setting its own professional standards.

Currently Australian osteopathic education is seen to be at the equivalent stage of educational program establishment to that of the American osteopathic scene of the 1940's, as osteopathic education has been established in Australian government funded tertiary institutions in the last twenty years. In regards to professional research, the Australian osteopathic profession resembles the American osteopathic scene of the 1910's, when research funding was provided by the AmOA; research funding being provided by the Australian Osteopathic Association (AuOA) only in recent years. Such funding has been integral for a profession to respond to demands academic credibility by the public and government (Peterson, 2003). The slow development of autonomous, independent and government funded institutional osteopathic programs with access to research facilities and funding has sacrificed academic credibility of the profession and its existence as a provider of health care. Abstract and specialized knowledge in Australian osteopathic practice has been limited to general musculoskeletal conditions in private practice. Interactions and collaboration with other health care professionals has been limited to personal communication between individuals in private practice. Training in health care is not undertaken in hospitals, community health care or multi-disciplinary facilities, where research and specialized knowledge can be developed and shared to promote all of the disciplines.

The profession relied on osteopaths migrating from the UK initially, because of the limited scope of Australian osteopathic practice. Subsequently, Australians who wanted to study osteopathy found that the British School of Osteopathy (BSO) produced graduates with knowledge and skills for the Australian scope of practice. Instead of training in American osteopathic schools, many Australians went to train at the BSO (Hawkins & O'Neill, 1990; Webb, 1977). Chasms and rifts between local and overseas osteopaths surfaced (Hawkins & O'Neill, 1990). Australian osteopaths did not belong to one association, but too many. One 'voice' was not apparent on professional and educational issues relating to their profession, and hostilities between osteopaths and their associations in Australia and the UK eventuated. Rivalry and unprofessional behaviour resulted between individuals and professional educational associations regarding the standard of Osteopathic practice (Hawkins & O'Neill, 1990). This behaviour provided the Australian medical profession with ammunition to discredit the osteopathic profession, as was the case in the USA (Gevitz, 2004). Owing to the lack of united professional direction and definition of the osteopathic scope of practice, the government and medical fraternity were forced to limit the practice of osteopathy.

As the number of complementary and alternative practitioners and their professions were increasing in Australia, the federal government in 1974 commissioned an inquiry to fully investigate and report on the practices of chiropractic, osteopathy, homeopathy and naturopathy. In 1977, what is commonly known as the *Webb* report was produced (Webb, 1977). The directive from the minister was to assess the scientific basis of these practices, the desirability of registering practitioners (and if so, under what conditions), and the relationship of these practices to other medical services in the community (Webb, 1977). In reviewing this directive, it becomes apparent that there was a need for Australian osteopathy to adopt a scientific and collaborative approach with the medical profession for recognition as a health care provider. The report further exemplified a number of issues of concern for the professions being reviewed, and recommendations were made to address these issues. In the subsequent thirty one years, Australian osteopathy has continued to falter in addressing issues raised in this report. Australian osteopathy in attempting to professionalize failed

to demonstrate unity in meeting professional standards set by regulatory associations, and did not have mandatory requirements for members being required to adhere to a code of ethics, that provided a form of public accountability required of a profession.

In relation to osteopathy, the report highlighted that osteopaths claimed to have a broad scope of practice treating a large range of conditions beyond the musculoskeletal system (Webb, 1977). Differences between alternative health care groups and professions were not clear and were grouped together (Webb, 1977). Practitioners claimed to belong to more than one discipline as studied more than one discipline at the same educational institution concurrently. The osteopathic profession was small with a large number of stakeholders in osteopathic education. The profession did not have consistent standards of practice between one osteopath and the other. The recommendations handed down in the Webb report included that chiropractic and osteopathy should not be given legal recognition in any form which would imply that they are alternative health systems. Chiropractors and osteopaths were eventually registered in each state and territory of Australia, and the legislation throughout the Commonwealth was uniform for both. Minimum educational standards were to be adopted for registration of chiropractors and osteopaths which would be facilitated by having a single new course at a tertiary institution (Webb, 1977). These recommendations would not have been surprising to the osteopathic profession, as it was seen to be closely aligned in development and practice to that of the chiropractic profession, particularly in osteopathy not being seen as an authority on musculoskeletal health care through mastery of specialized knowledge and through research to provide cost-effective services in meeting the health needs of specific community groups.

Based on the Webb report's recommendation, the chiropractic profession's proactive membership established an educational program at Preston Institute of Technology (PIT), which amalgamated with Royal Melbourne Institute of Technology (RMIT) in the 1980s (Hawkins & O'Neill, 1990). The chiropractic profession then began to establish statutory regulations through each state of Australia. In a number of states, chiropractic and osteopathy were regulated by the same act, but

there were also occasions where often only chiropractic acts were established. In these states, it was necessary for osteopaths to claim to be chiropractors rather than osteopaths to achieve registration (Hawkins & O'Neill, 1990). The Webb report, statutory regulations and legislation confined the scope of practice of these professions to the treatment and management of musculoskeletal disorders using manual medicine (Webb, 1977). The small number of osteopaths with a lack of resources to build up their professional status paralleled the osteopathic discipline with the progressive chiropractic profession. The more proactive chiropractic profession, with the advancement of their professional education in the tertiary sector, and with the establishment of statutory regulations in each Australian state can be viewed as having assisted osteopathy's professional status in the treatment and management of musculoskeletal disorders. Apart from its affiliation with members of the chiropractic profession, the osteopathic profession did not have influential and powerful people with strong social structures to sponsor its professionalization, as was the case in Britain and the USA. Max Weber has illustrated that this sociological perspective has been a major influence in the professionalisation of an occupation (Grbich, 2004).

Osteopathic training was undertaken in privately funded institutions until 1985, when an osteopathic program was established at Phillip Institute of Technology (PIT), alongside the chiropractic program. Since the founding of the PIT osteopathic program, Australian osteopathic education in Australia has been developing, with varying success. Three university courses in Australia had been established over the last 25 years. In 2005, the University of Western Sydney (UWS) osteopathic program was terminated, and at Southern Cross University (SCU), a new osteopathic program was established, its first intake being in 2007. All osteopathic programs have been established with minimal direction from the profession and other health care disciplines. Accreditation procedures had been established by state registration boards in this period, and the development of a national accreditation committee has provided some direction for these osteopathic educational programs. Australian osteopathic education has primarily been developed in universities complementary to other health care education. At the Royal Melbourne Institute of

Technology (RMIT), the osteopathic course has been developed in alignment with chiropractic and other health care disciplines. At Victoria University (VU), the osteopathic course has developed in affiliation with other health care disciplines, like Traditional Chinese Medicine (TCM) and nursing. The UWS osteopathic course developed in a school with podiatry, occupational therapy, TCM and Naturopathy, exposed to the educational needs of other professions. In an endeavour to establish its own sovereignty, osteopathy competed with the other programs for resources. Hostilities arose in each discipline towards each other, as one profession feared it would be submerged by the other. Yet with a very similar scope of practice, all disciplines would benefit from a common curriculum with shared resources.

Development of specialized knowledge for the professionalisation of Australian osteopathy requires interactions and collaboration with other health care professionals. Academic staff within a tertiary institution require collegial relationships in specialized professional domains to establish foundations in research and teaching. Views between educational and research academic individuals are personal and competitive, and micro-level communication between individuals establishes social patterns that allows an individual to construct meaning in their social environment. These individuals endeavour to survive in an educational and research environment beyond that of the osteopathic discipline. Eventually affiliation between academic staff and the osteopathic profession reduces as larger (macro-level) patterns that define social structures between potentially powerful individuals and groups are ignored. Specific interest groups in which academic staff collaborate with the profession, society and government provide power and control to be maintained by all. Habermas and Weber define such social structures as necessary in a society (Newman, 2004).

Since the late 1920s, American osteopaths practised equivalent methods to those of orthodox medical practitioners; Australian osteopaths have accepted a drugless practice (Hawkins & O'Neill, 1990). Australian osteopathic practice was similar to that of chiropractic practice, and osteopaths did not have the opportunity to practise otherwise since they were unregistered. Furthermore, osteopaths have had the opportunity to recommend over-the-counter analgesics and anti-

inflammatory medication, but have been less likely to do so (Hawkins & O'Neill, 1990). Australian Osteopaths also debated use of electro-physiological therapeutic equipment used primarily by physiotherapists (Hawkins & O'Neill, 1990), which had also entered chiropractic practice and their curriculum at PIT. Manipulation was the principal therapy for both Australian osteopaths and chiropractors. The development of education programs for the chiropractic and osteopathic professions at the same institution was both advantageous and cost-effective, however the individual sovereignty of each discipline was compromised.

Educational programs have focused on the treatment and management of musculoskeletal conditions. Osteopathic practice has resulted in adopting a generalist approach to providing musculoskeletal health care. Specialization has not occurred, as no specialist osteopathic colleges or associations exist in specific health care fields (like pediatrics, obstetrics, cardiology and other fields). The only specialization that has been attempted is that of completing a Master of Osteopathic Science degree in pediatrics at RMIT in between 1995 and 2000.

Today, with only three osteopathic educational programs and 1,200 osteopaths (one osteopath to 20,000 people) throughout Australia, osteopathy focuses primarily on musculoskeletal conditions in private practice. Australian osteopaths in academic programs are small in number with limited research skills and output. Until recently, government regulation of osteopathy has been established in coalition with that of chiropractic. This process has been advantageous in providing osteopathy with recognition. At this government regulatory level, though, osteopathy has suffered from a lack of autonomy and self-regulation of its scope of practice. Low numbers of osteopaths in academia, research and government authorities have been unable to address the direction and professional status of osteopathy in Australia (Baer, 2006; Cameron, 1998; Hawkins & O'Neill, 1990; Jamison, 1991; O'Neill, 1994; Webb, 1977).

Australian osteopathy has been slow in that it is developing abstract and specialized knowledge. Knowledge in the science and in the art of musculoskeletal health care has been established in

Australian osteopathic professional entry programs within private institutions and universities. This framework has provided Australian osteopathic programs with credibility, and the profession with some autonomy in private musculoskeletal health care practice. Access to knowledge and research sources in osteopathic practice within these institutions has been limited in the development (or advancement) of professional abstract and specialized knowledge. Research in developing abstract and specialized knowledge in Australian osteopathy has been limited. As a result, research has had marginal impact on the direction and scope of practice, and in providing osteopathy with authority in the musculoskeletal health care area. The profession is supported primarily by two associations, insurance companies and the government health authorities (Medicare, Comcare, and workers compensation). Processes of self regulation and accreditation have occurred on a state by state basis. The federal government is establishing one authority to manage and accredit all health care professions (including osteopathy) throughout Australia (Commonwealth of Australian Governments, 2006). Currently, legislation has been established in most states and territories of Australia, and in those states and territories where specific legislation does not exist, osteopathy is incorporated in legislation that regulates the practice of chiropractic (Baer, 2006; Cameron, 1998).

The development of abstract and specialized knowledge, autonomy, self-regulation and accreditation processes within the Australian osteopathic profession has allowed a mastery of knowledge and autonomy to be established in the area of musculoskeletal health care. Mastery of specialized knowledge and autonomy have not segregated into particular specialist areas of health care as has occurred in the UK and USA osteopathic professions.

7. Conclusion: Issues for professionalization of Australian Osteopathy

History has shown that society needed science to address deal with bacteria in the causation of disease, society's health issues, and acute health care conditions. Scientists and scientific knowledge supported the medical model that led to a monopoly of health, increased status, incomes and public financial support for medicine and occupations allied to medicine also benefited. In recent years, there has been a growth in non-orthodox medicine and the concept of medical pluralism (Gabe et al., 2004). Due to the decline in infectious diseases and improvements to the environment in the nineteenth and twentieth centuries the perception of health has shifted from the earlier view which emphasized the eradication of disease by biomedical means, to an emphasis on the social and economics determinants of health (Gabe et al., 2004). Both society and health care has experienced the effects of feminism in all sectors and domains of the community (Gabe et al., 2004). A decline in mortality at all ages, has led to an increase in average life expectancy from birth and an ageing population. Deaths from infections have decreased, population is higher with elderly such that disorders later in life are more common; which are more commonly chronic disorders. Major changes in the mode of health delivery and the organization of health care have occurred. Doctors could make decisions regardless of cost (Gabe et al., 2004). Today, hospitals are not seen as major providers of health care as they were in the 1960s. Professional autonomy and self regulation are subject to greater external scrutiny (Gabe et al., 2004). In 1970s, many countries recognized the need to contain health care costs, improve performance and outcomes, and turned to management for solutions (Gabe et al., 2004). A collision course between managers and health care professionals occurred. For the professionalization of Australian osteopathy to continue, recent societal needs and health care system changes need to be reviewed and a realignment of the profession is needed to deal with these societal changes.

Health service in the 1980s and 1990s moved into the private sector. An increase in private hospitals allowed the private sector to profit on the treatment of health conditions by increasing capitalisation, reduce costs, providing better services, reducing waiting lists and increase competition between private and public sector (Gabe et al., 2004). Health care became a commodity and patients became consumers. Consumer demand for private health increased, with dissatisfaction towards public health. Doctors could charge their own fees in private hospitals. Patients could jump the queue for elective surgery.

Micro and macro level changes in health care delivery became dependent on organizational processes (Gabe et al., 2004). A new level of organizational development has arisen and established by government and health care providers known as the meso-level. This level is defined as an intermediate layer of management and administration in society 'where policy and organizational and managerial processes tend to be concentrated' that relate to health policy and organizational theory (Gabe et al., 2004). It is at this level where privatization and managerialism of health care, occurs, where there is a reconfiguration of citizenship in relation to health care entitlements, and health care issues become policy. Institutional processes and organizations are becoming increasingly prominent in the meso-level of society in contemporary health care (Gabe et al., 2004).

The demand for research to validate and demonstrate a profession's effectiveness in the health care system has been increasing. Lay knowledge is producing health care policies based on outcomes or evidence based approach research by linking social and biological factors. Cost effectiveness is a major issue for the health care system due to the cost of chronic illness, particularly musculoskeletal disease; third highest cost to community currently. Australia's Health 2004 (Australian Institute of Health and Welfare, 2004) illustrates the current health needs of the community, and how outcomes based policies are being adopted and implemented by government, institutions and organizations.

This thesis reports on the gaps of Australian osteopathic professionalism and the author provides an informed opinion on how these gaps can be addressed in advancing osteopathy's professional status.

The Australian osteopathic profession is situated in a privileged position to contend with the bounds of evidence-based and complementary medicine. This would result in an enhancement of their professional status, as their educational curricula and scope of practice would be informed from evidence based, orthodox and complementary research. It is apparent that similar problems have plagued other professions in these countries, like physiotherapy. Successful American and British osteopathic professions have relied upon factors like the number and type of practitioner, the research profile of the profession, the educational institutions and opportunities, and the informed management decisions undertaken. These mechanisms and resources have been instrumental in the osteopathic profession expanding and becoming a stakeholder in primary health care.

Both American medical and osteopathic professions have independently progressed by establishing registration boards and professional education in universities, that has integrated with the missions of the government and tertiary education providers. Their professions have been established through specialization, quality assurance and research strategies to support professionalization. American medical and osteopathic graduate attributes have been integral to the advancement of these disciplines. American medical opposition to the acceptance of the osteopathic discipline acted as a catalyst to the improve osteopathy, such that both groups governed their own advancement, relatively independent of one another. The situation differed to an extent in the UK. The UK and Europe accepted complementary health care, and provided an environment for osteopathy to establish itself. The slow regulation of UK osteopathy may have been the result of a lack of medical opposition. With numbers of osteopaths increasing, leaders in research and education were being produced. When registration eventuated in the UK, the osteopathic profession had a number of well-informed and experienced individuals to accept the diverse roles required in the advancement of the status of osteopathy.

The limited number of osteopaths and resources may seem like a hindrance to the advancement of Australian osteopathy. The author believes that this is only a short term issue and may in fact be advantageous currently in having the profession collaborate with stakeholders in the health care system and developing a professional rational and united voice in a health care system where the number of osteopaths and resources increase.

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