LITERATURE REVIEW

Professionalization of Australian Osteopathy

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REVIEW:

Introduction to article

In this report the professionalisation of an occupation is investigated using sociological perspectives defined by recognised sociologists[1-3] in researching the professional status of osteopathy in Australia. Professionalism is reviewed in research and published literature as a sociological entity, rather than as a clinical practice entity by way of particular practitioner behavioural characteristics[4-6]. Micro-level issues relating to professionalism that affect macro-level issues in the professionalisation of an occupation[7] are discussed. Principles associated with professionalisation are derived from Eliot Freidson's work that documents the professionalisation of medicine[2]. To that end, definitions of professionalisation are clarified and the use of Freidson's professionalism principles in researching osteopathy in Australiais presented and discussed. Criteria for the assessment of Australian osteopathic professionalism are derived from sociological research literature and are used as a 'lens' to examine professionalisation and the current professional status of osteopathy in Australia.

Reference is made to several health care systems in which osteopathy is viewed as a profession. The health care systems of anglophone countries are reviewed to define the professional status of osteopathy in these countries[8]. Comparisons are made between Australia and other anglophone countries because they have similar cultures, lifestyles, health care and political systems. The discipline of osteopathy in these countries is defined and levels of professionalisation compared.

In Australia and internationally, osteopathy is regarded as a complementary and alternative medicine. In many countries, osteopathy has a restricted scope of practice governed by legislation or is unregulated; in the USA, osteopathy has the same scope of practice and recognition as medicine[8-10]. Osteopathy in the USA has maintained and advanced its professional status by addressing health care issues in society, and has promoted its existence by incorporating several sociological processes into its organisational structure.

At the end of this report, recent issues affecting society are identified in the context of health care provision by professions including osteopathy. The effect of these issues on the de-professionalisation of health care professions, including medicine, is not discussed in this report[2], because the current and future professional status of osteopathy in Australia is being addressed. Overarching concepts emerge in this report from the analysis of sociological issues that affect all professions. Professions have developed from societies that have been built on lay knowledge[11, 12], in which science has been used in a framework known as the *biomedical* model[11]. 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 health care needs and provision in what is known as *evidence based* medicine, or *outcomes based* medicine, and is important for osteopathy in Australiato comply with in its professionalisation.

This report provides a conceptual framework for defining the current professional status of osteopathy in Australia osteopathy and identifying gaps in the research literature relating to professionalism. The rationale for methods used to collect and categorise data, based on Freidson's principles of professionalism, are described. Analysis of the data allows the identification of internal and external sociological and organisational issues that affect osteopathy in Australia.

Sociological theory and definitions

The terms *'profession', 'professionalisation' and 'professionalism'* have been defined by several authors [3, 7]. This report adopts a sociological approach to the development of professionalism, and as previously stated, describes a sociologically-oriented investigation of osteopathy in Australia to determine what professional characteristics Australian osteopaths possess. 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[7]. Professions have been conceptualised using various organisational and sociological descriptions[13]. These descriptions allow the relationships between professions and society to be viewed using several 'lenses'. Organisational and sociological perspectives on professionalisation in health care from key authors in the sociology of this field[3, 7] include:

a) the ***conflict perspective,*** in which society is viewed in terms of conflict and struggle between different interest groups for power and control. Inequality and division between groups allow some groups to benefit at the expense of others[7]. Order in society evolves as groups pursue dominance from persuading government and societal institutions to legitimate their influence and power to generate benefits for particular interest groups.

   Karl Marx is a key proponent of this perspective, who argues that - with limited resources in society - individuals and groups seek power and dominance over other members by establishing organisations that influence society to serve their interests[7]. These dominant 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 the conflict perspective. Sociologists document the fact that women in most societies throughout history have possessed less power, influence and opportunity than their male counterparts, as traditionally women have been expected to undertake most household and family responsibilities, generally unpaid. Men have been

relatively 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[7].

Michel Foucault, another key author in sociology, illustrates the historical development of knowledge and power by increasing surveillance and control of health care provision by using educational and health care institutions (like hospitals)[11]. Within these institutions, knowledge relating to health, disease and illness was primarily generated to contribute to the professionalisation of medicine. Underpinning of the medical model is maintained through the generation of scientific knowledge about the working of the human body, while excluding unorthodox health care interest groups and professions from access to this knowledge. Social shaping of this scientific knowledge within these institutions allows a relationship between it and the understanding of health and illness for lay people in society to occur[11].

b) the ***structural-functionalist*** perspective, from which society is understood as an intricate and complex system consisting of co-ordinated parts, which each contribute to maintenance of harmony and equilibrium[11]. Individuals and groups within 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 proponent of the *structural-functionalist* perspective, and has conducted studies of illness behaviour and the 'sick-role' in relation to the doctor-patient relationship [11] and negotiated order. Parsons' model of the sick role is an 'ideal type', characterised by abstract generalisation and exaggeration of empirical reality[11]. The relationship between the patient and the doctor benefits both and is reciprocal and therefore unproblematic. When conflict in the relationship arises, it evolves from doctors' unrealistic expectations of how patients ought to behave when they consult.

One of Parsons' legacies relate to his concept of gender roles, in which men work as 'bread winners', and women work in family roles[11]; these roles were associated with beneficial and adverse health consequences specific to each gender. Furthermore, Parsons' functional perspective also identifies how marital status affects health – i.e., that married men and women have better health than single men and women[11]. These observations align with the structural-functionalist perspective that each co-ordinated part of a marriage contributes to maintenance of harmony and equilibrium in the 'whole'. (This relationship is further described by Erving Goffman[7], where people are viewed as autonomous beings yet highly dependent and constrained by one another. People in these relationships possess trust and loyalty for each other[7]. Boundaries exist between these beings in social environments such that together they act and demonstrate a common view and cohesion. The impression 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[7]. 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 their situation[7]. Micro-level communication between individuals establishes social patterns and allows individuals to construct meaning in their social environment[7]. These patterns run the risk of ignoring larger (macro-level) patterns that define social structures between potentially powerful individuals and groups in historical, institutional and cultural settings.

To understand professionalisation as a sociological entity, this report provides an assimilation of the perspectives, in which one perspective complements the other, and the above perspectives contradict each other.

Data collection via surveying and interviewing would allow the disarticulation of issues within the osteopathic profession. The collected data would provide a basis for categorising the professionalisation of osteopathy in Australia, within the scope of the abovementioned sociological perspectives. The outcome of analysis should include an assessment of key informants' perception of osteopathy in Australia compared to the profession as a whole, and identifying gaps in osteopathy in Australia professionalisation in sociological terms. Aspects of Australian osteopathic professionalism to be considered include:

a) specific interest groups within society and government that affect power and control within and external to osteopathy in Australia;

b) issues of gender, access to economic, educational and political systems, and possession of esoteric and scientific knowledge;

c) any alliances with individuals, groups or professions 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 towards other health care professions, and Australian osteopaths acting and demonstrating cohesion with other health care professionals. Stability and power accrue to health care professions as the success of teamwork and professional conduct are recognised by society[7]. These professions operate and deal with competitive societal environments by establishing understanding and trust between closely related professions to manage the political struggle in dealing with conflicts in the social issues of professionalism[14].

d) Australian osteopaths' 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 interactions between the profession and the society.

In his work prior to 1970, Freidson listed a set of important characteristics for defining professionalism[15, 16]; subsequently, Freidson shifted his focus from attributes of professions to the process of professionalisation[17]. Freidson's shift in focus was analogous to changes in current professional and organisational relationships that are required in the process of professionalisation. The use of Freidson's principles of professionalisation in researching osteopathy in Australia exposes relationships, barriers and conflicts within and external to the profession. Internal and external issues (for example, education and research) influencing the professional status of osteopathy in Australia can be segregated and researched using organisational and professional 'lenses' to identify gaps in the professionalisation of osteopathy in relation to competitive societal environments and the political struggles and conflicts encountered.

Professionalism as a concept has developed over the past hundred years. The terms professionalism, profession and professional are confusing as all occupations claim to be professional, yet no occupation is known to meet all the ideal criteria for professionalism as defined by Talcott Parsons (1964) [cited in 1] and Eliot Freidson[2]. Professionalisation refers to the process by which an occupation becomes recognized as a profession. Characteristics of a profession include the ability to regulate work practices, demonstrate autonomy, achieve status and prestige in society, and have power to direct policymaking[9, 10, 18]. The professionalisation of occupations occurs to meet community needs, such that members of an occupational group have integrity and are committed to their society. Divinity, Medicine and Law are classical professions which display these characteristics. Over the past hundred years, modern medicine has achieved the highest professional status of any occupation related to health care[3, 11, 18, 19].

Osteopaths have been working in Australia since the early 1900s, yet they have not achieved the same professional status as medical practitioners and other health care providers such as physiotherapists[20, 21]. The logical next step is to make a comparison between the status of osteopathy in Australia and that of medicine, such that gaps in Australian osteopathic professionalism can be identified.

Controversy still exists on the process of professionalisation. Models and theories of professionalism are simplified representations of reality. Tones[22] states that models allow a focus on the most important issues. Models that are accurate and comprehensive analogues of reality enable explanations and predictions to be made in relation to unknown aspects of our world.

Eliot Freidson documented his theory and model of medical professionalism since the early 1970s in his text "Professionalism – The third logic"[23]. Freidson's model of professionalism identifies sociological approaches for establishing, reporting and co-ordinating components of developing a profession. His model can be viewed as a set of interrelated and interdependent ***principles*** arranged in a manner that produces a unified whole and is 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 organisation are differentiated. Similarly, professions can be characterised by using sociological perspectives that have been defined similarly by other authors[1, 3, 7, 24]. 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 osteopathy in Australia can be conceptualised into performing specialised and integrated activities that are guided by principles and mission statements for the development and advancement of professionalism.

Freidson's work is used as a framework in this report as it relates closely to professionalism in health care, and is based on a profession that has attained a high level of professional status - that of medicine[2]. Freidson followed the emergence of the medical profession the most closely of all sociologists and became the most prolific author in the study of medical professionalism. His publications have considered and argued other sociological perspectives to arrive at a set of principles for developing professionalism and defining professionalism within an occupation.

The conceptual framework of this report is based on Freidson's six principles of professionalism[2]. In brief, Freidson argues that professions have:

1. abstract and specialised 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 their constituents expect compliance with their directions and advice, which is based on mastery of the body of specialised 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 Freidson's principles of professionalism as a lens for reviewing osteopathy in Australia is applicable, as osteopathy represents an entity in the health care community comparable to medicine, law, religion and other health care professions.

The models proposed by Freidson and other authors illustrate that three aspects underpin medical professionalisation[24]. Firstly, the proposed medical professionalisation models are based on a conceptualisation of disease as the occurrence of biological events independent of social factors. Secondly, abnormal health conditions are due to mechanical processes, in which disease and dysfunction are the result of bacterial and viral infection that affect interdependent parts of body, independent of a person's psycho-sociology. Thirdly, disease and dysfunction producing abnormal health are investigated, treated and managed using scientific means. The medical profession has

used this body of specialised knowledge to provide important health services to the community. In claiming this body of knowledge as its own, medicine gained power to organise and control its future and that of other health professions. The medical profession developed interconnected institutions of knowledge generation, utilisation and control, including hospitals and educational faculties in colleges and universities. Stability and promotion of these institutions occurred with economic support and social organisation from government. Occupational control of health care was achieved by the medical profession,[2] as education provided the knowledge and training that allowed medical professionals to assume positions of authority within organisations, government and the broader community.

Once in positions of authority, 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. From a functionalist sociologist's point of view, the medical profession was able to maintain control and power, by attaining autonomy from an exchange with society that allowed the profession to maintain its own regulations and standards and in return provide expert service to society in the area of health care[2]. This view implies that such an exchange is a continual process between a profession and society; normally, society would regulate such a process and restrict a profession's autonomy[3, 7].

Medicine demonstrates a responsibility to protect and to enhance its knowledge and to use it in the public interest. Its practitioners have concern for others and make up a moral community in which some degree of self-sacrifice exists, whereby professionals go beyond self-interest or personal comfort so that they can help a patient or client. However, the medical profession – thanks to its esoteric knowledge of health care, and doctors in positions of authority within organisations and government - possess the right to self-regulation and expand their autonomy. Within government and other powerful organisations, members of the medical profession develop and administer 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[2].

Medical practitioners achieve authority based on their mastery of a body of specialised knowledge and on their profession's autonomy, and their opinion/advice is accepted in all sectors of the health care system without argument; society is compliant to their demands and needs for their existence. Medical practitioners' demands included being well paid and having high status in society, as professional people were seen to work for profit, while non-professional workers (amateurs) work because of motivation[2]. Medical practitioners were typically seen to be members of the upper class, and became associated with upper class professions[25]. From a functional sociologist perspective, pay and prestige serve to ensure the continued attraction of the best and brightest people to professional careers, while conflict sociologists believe that professionals use their monopolistic control to ensure that they are well-paid[2].

Professions other than medicine did not defend themselves well against medicine's control of health care. These professions worked in health care systems with different vested interests and attacking each other rather than recognising shared arrangements. No principles were spelt out by these professions in organising and supporting their work and responsibility[2]. 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; for example, pharmacy advanced the professionalisation of medicine by promoting and maintaining the social and political interests of doctors[11].

Freidson also illustrates that in the process of professionalisation, specialisation occurred in medicine as part of a coordinated plan to transfer knowledge to expert domains within the health care system, including pediatrics, surgery, pharmacology, gynecology and orthopedics. The result was that the medical professions' specialised work became even more inaccessible to other professions. This form of specialised training is known as *discretionary* specialisation, and is contrary to *mechanical* specialisation that involves knowledge and skills for everyday living[2].

Costello[26] presents an analysis of professionalisation and 'medicalisation' in which the medical profession is shown to focus on the science of teratology in obstetrics, which was marketed as a science through publication. 'Medicalisation' is defined as the process by which human conditions and problems come to be defined and treated as medical conditions and problems, and thus come under the authority of doctors and other health professionals to study, diagnose, prevent or treat[27-29]. Costello[26] contests the veracity of the underlying evidence, stating 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[26] of their superior skill and knowledge in obstetrics. Selective under-reporting and over-reporting of obstetric conditions in publications assisted these obstetricians in achieving professional goals, by using the power of publication to convince other medical practitioners and the 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 childbirth would improve prevention, diagnosis and cure of disease. The progress of science in this domain shaped a significant part of medical ideology, and served the purpose of establishing obstetrics as a profession[26].

The medicalising of childbirth allowed obstetricians to define problems and to control access to solutions through superior and abstract knowledge and medical science[26]. Gender politics in the field of obstetrics prevailed, as the prestigious and well-remunerated obstetricians were primarily male, while poorly-paid and low-prestige midwives – who were expected to be more caring than male obstetricians, but had less valued technical knowledge - were primarily female[26].

According to Costello[26], 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. Obstetricians demonstrated altruism by volunteering to work in hospitals and aligned themselves with general practitioners (private practice). Competition between the two occupations occurred as obstetricians launched a joint effort with medical

practitioners against midwives, segregated themselves from the term ‘midwife’ when gender relationships developed within obstetric health care, and by affiliating themselves with hospitals. Politics prevailed as obstetricians mobilised to increase the number of births in hospitals, at a time when risks and deaths in hospitals were increasing. It became apparent that the medical profession had been effective in convincing the regulators that medicalisation of obstetrics should be promoted, even when this went against the evidence[26].

However, Freidson[2] states that professions should not lose sight of the fact that they are not defined on a list of characteristics, but as the result of a process of social definition. Freidson[2] states that ‘Ultimately, clients, members of related professions, and the broader society determine whether an occupation achieves and retains professional status.’ Freidson[2] also emphasizes that ‘Professionalisation 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[2].

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[11, 12]. Lay knowledge is not ‘residual’, but complex bodies of knowledge and contextualised rationality that are central to understanding of culture and society. This knowledge contains empirical approaches to everyday life and situates personal experiences in relation to broader frameworks of existence in society. 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[11]. Lay knowledge brings about an integrative and holistic approach to health care, that is supported by views, attitudes, beliefs and experiences of individuals in society.

When properly used, this type of knowledge allows for a rational approach to health provision that prevents the clash of perspectives[11]. The effect on a health care system of allowing

complementary and alternative therapies to exist in a society where the biomedical model of health care dominates is profound. Society adopts processes for validating and utilising the strengths of complementary and alternative therapies; evidence is sought through research undertaken by government, consumer groups, educational institutions and health professionals to integrate these therapies into the health care system[3].

Surveying the Australian osteopathic profession and interviewing key informants allows the researcher to collect and analyse data by compartmentalising the data in relation to Freidson's principles of professionalisation. Data are analysed to identify the current professional status of Osteopathy in Australia and the existence of any gaps (if any) in Australian Osteopathic professionalisation. By surveying Australian osteopaths and interviewing key informants, abstract and specialised knowledge that exists in osteopathic practice is contextualised, and allows identification of 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. The data allows investigation of the extent of specialised knowledge generation and related research being undertaken to give the osteopathic profession recognition as an authority in health care, particularly in the management of musculoskeletal conditions.

Development of osteopathy as a profession

Osteopathy is an internationally-recognised profession[30, 31]. 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)[32, 33]. *Alternative* medicine is known as a health care discipline "that does not fall within the realm of conventional medicine"[34]. Commonly cited examples of alternative medicine 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 incorporate or are based on traditional medicine, folk knowledge, spiritual beliefs, or newly conceived approaches to healing and well-being. In some countries, alternative medical practices may be regulated by government. The methods of alternative medicine practitioners are generally not accepted by the medical community because of the lack of evidence documenting their safety and efficacy. Once the safety and effectiveness of an alternative medical approach or therapy has been established, it may be adopted by conventional medical practitioners.

Grey literature[35-37] provides succinct historical accounts of major events that have influenced the development of osteopathy in the USA, UK and Australia. The grey literature consists primarily of government reviews and commentaries by osteopaths that describe the development of osteopathic educational programs, legislation and scope of practice in each of these countries[8-10, 38-40]. Common to all of the grey literature is a lack of comment and analysis in regards to the professionalisation of the discipline in each country. This report provides a basis for answering the research question “What is the current professional status of osteopathy in Australia?” by specifically filling the gap in the literature; the lack of delineation and identification of sociological processes that affect the professionalisation of the osteopathic discipline.

The report also investigates health care systems in other countries where the osteopathic discipline exists. Anglophone countries in which osteopathy is viewed as a profession have elaborate health care systems. Australia is one such country in which health care should be viewed broadly, as it is delivered by both conventional (or orthodox) professions and complementary (or alternative) health care professions. 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 established sixty years ago by the World Health Organisation (WHO) that described health as 'a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity'[41, cited in 42]. Providers and professions in Australian health care deliver primary and secondary outpatient care through private practice, hospitals, outpatient clinics and primary health care facilities. General or medical practitioners generally coordinate care and referrals, serving as formal gatekeepers in the Australian health care system.

Health services in Australia are funded by private health insurance companies, and public and private health authorities. The federal government administers a compulsory national health insurance program, known as Medicare. Medicare is funded by a mixture of general tax revenue, state government revenue, and fees paid by patients. Governments fund 68% of health expenditures (45% federal and 23% state) and the federal government has control over hospital benefits, pharmaceuticals, and medical services[43]. The states govern public hospitals and regulate all hospitals, nursing homes, and community-based general services. States pay for health services in public hospitals via five-year agreements with the federal government[43]. Private health insurance companies generally cover the gap between Medicare benefits and schedule fees for inpatient services, and subsidise 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[42], 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 away from the highly regulated medical approach to Australian health care brought about by a holistic health care movement and the increasing popularity of alternative therapies. These alternative therapies have been collectively defined in several ways, but are principally known as *complementary and alternative medicine* (CAM)[32, 44]. The rise of CAM approaches in the provision of health care has led to the integration of the biomedical and CAM models, and *integrative medicine* has become a recognised term in Australian and international health care systems[44].

In Australia the osteopathic profession exhibits features of a complementary health care provider within the health care system, as in the United Kingdom (UK). Osteopathic practice is primarily conducted in private health care clinics[9] focusing primarily on the management and treatment of musculoskeletal conditions. The Australian osteopathic profession operates very differently to its equivalent in the USA, which enjoys primary health care status and has access to all sectors of health care provision and training opportunities[9, 10, 45]. Australian osteopaths are recognised as providers of musculoskeletal health care by all private insurance companies and all government authorities, but physicians / medical practitioners act as gatekeepers to the provision of government-funded osteopathic services (such as Department of Veterans Affairs services and Enhanced Primary Care (ECP) plans). Thus, while Australian osteopaths may have access to government hospital funding, gatekeepers of Australian hospitals, primary government health care authorities and facilities have refrained from employing osteopaths for the provision of health care services. Osteopathy in Australia osteopathy claims to possess 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. Nevertheless, in the Australian health

care system, osteopathy has the professional status of a complementary and alternative health discipline[32, 33].

The integration of professionalised osteopathy in health care systems around the world has occurred in several different ways, as the discipline has been exposed to societal, government, educational and professional issues that vary across countries[8, 39, 46]. The history of the osteopathic professions has been documented by authors who have described their development in Australia[9, 38, 46, 47], in the USA[10, 39, 48-50] and in the UK[51]. Government reports in Australia[40] also provide a societal perspective of osteopathy in Australia. These authors cite various strengths and weaknesses in the fortunes of osteopathy in Australia and internationally, which are discussed in this review This report summarises and identifies relevant issues relating to the professionalisation of osteopathy and evaluates the effects of these issues on the profession[52]. The main mechanism for advancement of a profession's status (professionalisation) has been identified as a continuous cycle of quality assurance in addressing societal needs based on a biomedical and sociological model of health care[8-10, 48]. 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 medicine and other professions internationally, and in the osteopathic professions of the USA and UK which have expanded and prospered. Government policies, societal influences, educational and professional issues are critical to the professionalisation of osteopathy in Australia.

Publications relating to Australian osteopathic professionalism are scarce. As stated above, some gray literature on osteopathy in Australian exists but adds little to the study of its professionalisation. Overall, as described it the previous section, there is very little documentation of the existence of osteopathy in Australia as a profession.

In this section, sociological perspectives and Freidson's principles of the development of professionalism are used as a 'lens' to examine osteopathy in Australia, the USA and the UK. Anecdotally, using grey literature, osteopaths in the USA and the UK have higher professional status relative to their Australian colleagues[8-10, 38, 39]; an assessment of osteopathy's development in the USA and the UK may reveal means by which osteopathy in Australia could professionalise further.

Professionalisation of osteopathy in the United States

American Osteopathy was founded as a health care discipline in the late nineteenth century when many groups of healers were neither well established nor well organised. In the post-civil war period, no licensing boards and few scattered state laws governed medical and health care practice[39]. 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[10]. 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[10, 48].

With medical licensing and regulatory agencies in a splintered state, medical training was primarily based on a guild system (the apprenticeship approach). As the medical fraternity in the USA was establishing itself in the 20th century , osteopaths, allopaths and homeopaths were also seeking recognition as health care disciplines[39, 48]. Professional groups conflicted over their respective domains and scopes of practice[48]. Eventually, in 1847, the American Medical Association

(AMA) was founded and standards of medical education were established[39]. The AMA and its affiliate societies then began to lobby the state regulatory boards to support the advancement of its professional status. The AMA became more stable, successfully establishing the medical profession as the primary provider and arbitrator of health care in the community. Complementary and alternative health care approaches (included osteopathy) were not accepted by the AMA and 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 Kirksville, Missouri, USA in 1889[53]. Around 1864, Still watched as the therapies of his medical colleagues failed, and three of his family died due to meningitis. This incident was the precursor to the founding of osteopathy. Still yearned to develop a discipline that could provide health care where medicine had been unsuccessful. Although lacking formal qualifications, he was a medically trained practitioner to all intents and purposes; he had received considerable medical training from his father and had spent many hours studying textbooks on anatomy, physiology, surgery and *materia medica*[10, 39, 44, 48]. In the early 1870s in Kirksville, Missouri, Still began to practice his own style of health care using manipulative/manual medicine and physical therapies, while condoning the use of heroic therapies[10]. His physician colleagues criticised him and distanced themselves from him; Still's practice did not flourish until he successfully treated several prominent community members, who had undergone unsuccessful medical treatment from other physicians[10]. These prominent individuals eventually became sponsors for Still's style of health care practice, and ultimately 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 in May 1892.

Hawkins and O'Neill claim that the osteopathic discipline was institutionalised and secured with the establishment of the American School of Osteopathy (ASO) in Kirksville, Missouri[39]. The ASO increased the popularity of osteopathy throughout the USA, and several private training institutions

were established[39]. The professionalisation of osteopathy continued, as the ASO developed esoteric and specialised knowledge for osteopathic practice.

With the increasing popularity of osteopathy and following the establishment of the ASO, in 1893 the medical fraternity of Missouri endeavoured to legislate that osteopathy practitioners should be graduates of a reputable medical school[48]. After legal challenges by the medical fraternity and vigorous opposition from osteopathic patients, sponsors, and the profession, a separate osteopathic bill was proposed. This bill was vetoed by Missouri governor William Stone, on the basis that osteopaths were insufficiently educated. Initially this event seemed to be disadvantageous to the developing osteopathic profession as it delayed the professionalisation of American osteopathy and allowed other professions like medicine to establish themselves and claim societal resources, authority and recognition as a health care provider. Between 1893 and 1896, the ASO realigned its training curriculum to be consistent with that of a standard medical teaching program, excepting the exclusion of *materia medica* from 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[48]. Academics, in developing esoteric and specialised knowledge at the ASO, sided and collaborated with specific interest groups within society and government that had power and control[48]. These special interest groups advised academics at the ASO on curriculum and knowledge required to meet the health needs of society[48]. The advancement of the professional status of American osteopathy resulted from an awareness of 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 osteopathy profession and the society[2, 7].

The societal patterns that promoted the professionalisation of American Osteopathy were also dependent on the diversity in profile of the ASO staff and students. Gevitz describes how the ASO accepted migrants, females and indigenous black people as students in higher proportions than were admitted to medicine courses at American universities[48]. Altruism prevailed as a professional trait at the ASO, as a many of these students were only able to attend the School because their fees were waived. 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'[38]. 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 sound mental habits, and the ability to grasp basic laws and principles that could be applied to any particular situation. Knowledge empowered the ASO graduates and provided them with the abilities to deal with societal demands placed on their practice and the profession. These ASO graduates inherently acquired leadership attributes for the field of osteopathy in the USA. Graduating osteopathic practitioners treated people of lower socio-economic status who were in great need of health care; all populations of the USA were able to access osteopathic health care[8-10, 38, 39]. 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[38]. The social implications of the professionalisation of osteopathy were vast, as the diverse 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 members of the community.

Between 1897 and 1901, the American Osteopathic Association (AOA) was formed by the alumni of the ASO and several other osteopathic schools. The executive of the AOA consisted of dedicated and motivated osteopaths who used their leadership and management skills for the advancement of the AOA's professional status[39]. In 1901, the Committee on Legislation within the AOA 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[48]. The values and powers of critical judgement and the imaginative insight of osteopathic graduates on this AOA committee provided leadership for the profession. These representatives were able to convince the government that members of the 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 AOA representatives[48]. By 1903, the AOA had formed the Council on Medical Education (CME). The CME adopted standards for the approval of osteopathic training; the effect was the demise or merger of several osteopathic institutions. The CME provided an informed and united view of an osteopathic curriculum to meet the needs of the training institution, community and profession. As the AOA evolved, the membership of its committees and councils continued to educate itself and expound highly specialised 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 AMA formed its own Council on Medical Education, which also adopted standards for the approval of medical training that similarly led to the demise or merger of medical and osteopathic institutions[39]. The AMA began inspecting medical training institutions, accrediting those with appropriate standards. Often the accredited institutions were affiliated with universities with access to science faculties and stable funding that were important in the establishment of specialised knowledge and for developing societal communication with government, academia, and the wider community. Accreditation of osteopathic training institutions was not undertaken by the AMA, so the AOA was able to fill that niche and place itself in a privileged position. The AOA accredited osteopathic training institutions, allowing it to maintain control and develop 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 those countries. The *Flexner* report was highly critical of osteopathic training institutions[54]. The terms of reference of this report were 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 [sic] 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.'[54]

The Flexner report included several recommendations which were adopted over the next twenty-five years by the AMA[54]. 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.

All eight osteopathic training institutions operating in the US and Canada were reviewed by the Flexner report; the impetus behind their inclusion was another sponsor of the osteopathic discipline, Henry Pritchett. Henry Pritchett was the head of the Carnegie Foundation and had experienced osteopathic treatment[48]. Flexner supported Pritchett's determination to include osteopathic institutions in his review, as Flexner held 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.'[54]

Flexner then reported that:

'... no one of the eight osteopathic schools is in a position to give such training as osteopathy itself demands.'[54]

Flexner's unfavourable review produced considerable upheaval among the AOA Board of Trustees and accredited training institutions. The AOA Board of Trustees and accredited training institutions felt that educational reform for the osteopathic profession would be challenging[48], though the AOA Committee on Education agreed substantially with the Flexner report[48]. Further debate and disagreement in the AOA, between the Board of Trustees, the accredited training institutions and the Committee on Education resulted, and the outcome was that the AOA and osteopathic training institutions did not embrace the Flexner report's recommendations, in contrast to the medical profession. This resulted in the medical profession expanding and consolidating its position as the primary health care provider, providing increased access to funding through taxes, public and private general university funds, and philanthropy[48]. 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[49]. 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 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. The sociological processes that transpired included alliances with individuals and groups that shared a common interest in maintaining a viable and efficient health care system. American osteopathic autonomy developed that demonstrated a common view and cohesion with that of other health care professionals. Stability, status and power eventually derived from American society's recognition of osteopathy's professional processes and outcomes. Eventually, the osteopathic profession developed policies and strategies that incorporated the changes recommended by Flexner report, and the professionalisation of American osteopathy continued.

The American osteopathic profession had unconsciously built a continual process of quality assurance, which included challenging 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 respond to those challenges and enabling osteopathy to prosper in a competitive environment. AOA lobby groups set an agenda to reduce the medical profession's dominance and to encourage government to pass laws which guaranteed acceptance of the osteopathic profession. In time, the federal 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[39].

Speciality health care training was incorporated into osteopathic curricula to meet demand and to facilitate research. Hospitals and health care training facilities were provided to facilitate the

integration and collaboration of osteopathy with mainstream health care. Research institutes were established [39] 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 AOA 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 and enabled to grow.

Professionalisation of Osteopathy in the United Kingdom

In the 19th century, complementary therapies were considered acceptable forms of health care in the UK and Europe. Over many centuries, European health care had developed defined therapies and groups of healers in society which were accepted and viewed as effective. Thus, in Europe, and particularly the UK, the new discipline of osteopathy was entering a society with liberal views on the provision of health care. In ancient Greece, manual therapy was used to treat a wide range of ailments and was later adopted by the Romans[48]. French, German, and Scandinavian physicians promoted the use of manual therapy in their scope of practice in the late 1800s[48]. Peter Henry Ling (1776-1839) popularized his manual therapy approach known as 'Swedish Movements' - initially dismissed but later accepted by the Swedish medical community[48]. In the 19th century the European medical fraternity was able to distance itself from these therapies and healers, however they continued to survive. Practice of manual therapy and the publication of hundreds of articles and books on this approach resulted in successful outcomes in cases where medication had been unsuccessful[48]. Acceptance of manual therapy and its establishment as lay knowledge in European society allowed disciplines like osteopathy to become established. Similarly, homeopathy was launched in Germany by Samuel Hahnemann (1755-1843), and subsequently prospered throughout Europe. Homeopathy was also integrated into the scope of practice of several early

American doctors in the late 1800s[48]. In summary, the European health care scene had long accepted complementary and alternative forms of health care, facilitating the rapid establishment of osteopathy in the UK in parallel with firm societal views and existing lay knowledge.

The beginning of the 20th century was a fertile period of time for osteopathy to develop as a distinct profession in the UK. In the 20th century, the UK's first osteopathic college was established by a Scotsman, John Martin Littlejohn, who had studied under 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[51]. Littlejohn founded the British School of Osteopathy (BSO), the first osteopathic education institution outside the USA. This event signified the start of the professionalisation of British osteopathy, with the institutionalisation of esoteric and specialized knowledge that formed the foundation of osteopathic practice. At the BSO, British osteopaths were taught the use of manipulative techniques based on 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) was founded in 1927, and became a prominent osteopathic training establishment, following an American curriculum and seeking recognition for its graduates as medical practitioners. When LCOM's endeavours to have its graduates recognised as medical practitioners proved unsuccessful, it became an avenue for mainstream British physicians to supplement their training with an osteopathic education[40, 51]. Unlike the situation in the USA, animosity between the medical fraternity and the osteopathic profession in the UK failed to eventuate, because the LCOM and the other British osteopathic training institutions provided the profession with respect and integrity. Whether the American medical profession's failure to control the osteopathic profession induced the British medical fraternity to avoid confrontation with their own osteopaths is unknown; the result for the British osteopathic profession was the attainment of independence as a distinct and complementary health care profession[8, 51].

Despite the gains described above, further recognition of the British osteopathic profession was slow. Laws governing the registration of osteopaths and scope of practice were not enacted until 1993, when the professional status of osteopathy had increased. By this time, the profession included powerful people in strong social structures, and provided osteopathic treatment to and was sponsored by powerful people - including the British Royal family, George Bernard Shaw, athletes and members of sports and Olympic committees of Germany[51, 55]. The Profumo Affair also illustrated the close affiliation of osteopathy with influential and powerful people in the UK[56] that were able to promote osteopathic practice as to individuals that would facilitate the professionalisation of the profession. Max Weber describes the mingling of an occupation with influential and powerful individuals as a major sociological influence in the professionalisation of an occupation[3].

Apart from the beneficial 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. Another positive development was the British osteopathic profession's instigation of the General Council for Registered Osteopaths (GCRO) on 22nd July 1936. The GCRO registered osteopaths who had trained at reputable privately-funded and charitable osteopathic educational institutions recognised by the NHS and private health insurers. Throughout the 1900s, government received proposals from the GCRO and representatives of the osteopathic profession to register osteopaths from reputable establishments with high educational standards. This strategy also forced fledgling osteopathic institutions to improve their education or fade away. In increasing and regulating the specialised 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; the Act contained provision for the formation of a professional self-regulatory body, the General Osteopathic Council (GOC), which was formed from the GCRO. The Act established its purpose as the regulator of the profession, protecting the public through maintenance of a practitioner register, investigating allegations of professional misconduct, and ensuring the quality of training via accreditation of osteopathic institutions. The Osteopathy Act provided the British osteopathic profession with legislative 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 Act allowed government health care policy to change to accept osteopaths in health care research; one such example is a collaborative research project documenting the effectiveness of osteopathy in back pain[57]. Within the European Union (EU) there is no standardised training or regulatory framework for the osteopathic profession, although attempts to coordinate this are being made. At present there is a conflict between the principle of free movement of labour and the right to practice osteopathy in different EU member states. Prior to the 1980s, 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[51]. Recently, the GOC issued a position paper on pan-European regulation of the profession[58], which aims to maintain osteopathy's status as a health care provider in 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 in which the quality of training may be substandard.

Professionalisation of osteopathy in Australia

Osteopathy arrived in Australia in the late 1880s from England and the United States. In this period of Australian history, very few occupations were recognised as professions[38, 40, 46]. Australian osteopaths were few in number and isolated from each other, and could not be said to belong to a profession. Other health care practitioners were relatively numerous in the 1880s and began forming guilds, colleges and associations, and eventually professions. Professionalisation of osteopathy in Australia differs greatly from the development of osteopathy in the USA and UK.[8, 9, 33, 38, 40, 46, 47, 59, 60].

The first osteopaths arrived in Australia from the USA under the assumption that they would develop a profession with characteristics similar to those of their American counterparts[38, 40, 46]. However, in 1910 (when the Flexner report was produced in the USA) there were only five osteopaths in Victoria, and even fewer in other Australian states[38]. Compared to the contemporaneous American osteopathic profession, the Australian osteopathic scene had essentially no capacity to develop a proactive profession. There were no Australian osteopathic training institutions, and any osteopathic training that was undertaken used a guild system approach[38]. Osteopathy in Australia was in its infancy in the early decades of the twentieth century, and grew slowly.

Osteopathy in Australia during the early 1920s endured the same adversity that the profession had sustained in the USA same period. History reveals continual opposition from the medical profession towards the acceptance of osteopaths as primary health care professionals. Hawkins and O'Neill claim that the medical profession's antipathy towards osteopathy inhibited the development of the Australian osteopathic profession[38]. Evidence of the Australian medical profession's opposition was apparent as early as 1927, when three Australian osteopaths were 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 Court's verdict defined the scope of Australian osteopathic practice, limiting it to the diagnosis, management and treatment of musculoskeletal conditions[38]. In this manner, the Australian medical profession was instrumental in preventing osteopaths diagnosing, managing and treating the full range of 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.

The profession relied initially on osteopaths migrating from the UK, 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 appropriate knowledge and skills for the Australian scope of practice. Instead of training in American osteopathic schools, many Australians went to train at the BSO[38, 40]. Chasms and rifts between local and overseas osteopaths surfaced[38]. Australian osteopaths did not belong to one association, but to 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 occurred between individuals and professional educational associations over the standard of osteopathic practice[38]. This behaviour provided the Australian medical profession with ammunition to discredit the osteopathic profession, as was the case in the USA[48]. 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.

In 1974, as the number of complementary and alternative practitioners was increasing in Australia, the federal government commissioned an inquiry to fully investigate and report on the practices of chiropractic, osteopathy, homeopathy and naturopathy[40]. In 1977, what is commonly known as the Webb report was produced[40]. 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[40]. In reviewing this directive, it is apparent that there was a need for osteopathy in Australia to adopt a scientific and

collaborative approach with the medical profession to achieve recognition as a source of health care services. The report further exemplified several issues of concern for the professions being reviewed (namely a fragmented profession, without consistent education or standards of practice), and recommendations were made to address these issues. Over the subsequent thirty-one years, osteopathy in Australian continued to falter in addressing issues raised in the Webb report. Osteopathy in Australia failed to demonstrate unity in meeting professional standards set by regulatory associations, and did not mandate osteopaths to adhere to a code of ethics that would provide a form of public accountability appropriate to a profession[38, 40, 46].

The Webb report highlighted that osteopaths claimed to have a broad scope of practice, treating a large range of conditions beyond the musculoskeletal system[40]. The osteopathic profession was small with a large number of stakeholders in osteopathic education, and did not have consistent standards of practice. The Webb report recommended that chiropractic and osteopathy should not be given legal recognition in any form which would imply that they are alternative health systems. Minimum educational standards were recommended for registration of chiropractors and osteopaths, which would be facilitated by having a single new course at a tertiary institution[40]. 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. The Australian osteopathic profession was not viewed as an authority on musculoskeletal health care, lacking a mastery of specialized knowledge and research. Osteopathy in Australia was not able to demonstrate 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 Philip Institute of Technology (PIT), which amalgamated with Royal Melbourne Institute of Technology (RMIT) in the 1980s[38]. The chiropractic profession then began to establish statutory regulations through each state of Australia. Despite Webb's recommendations, chiropractors and osteopaths were eventually registered in each state and territory of Australia by the early 1990s, and uniform legislation was adopted throughout the

Commonwealth[38, 40, 46]. In Victoria, New South Wales, Queensland and the territories chiropractic and osteopathy were regulated by the same act, but in others only chiropractic acts were established; in these states, it was necessary for osteopaths to claim to be chiropractors rather than osteopaths to achieve registration[38]. The Webb report, statutory regulations and legislation confined the scope of practice of the chiropractic and osteopathic professions to the treatment and management of musculoskeletal disorders using manual medicine[40]. The small number of Australian osteopaths meant few resources were available to build up their professional status. The more proactive chiropractic profession, which had advanced its professional education in the tertiary sector and been more favourably treated by statutory regulations, was an important contributor to the development of osteopathy's professional status. Max Weber has illustrated that influential and powerful people have a major influence in the professionalisation of an occupation[3]. Apart from its affiliation with members of the chiropractic profession, the Australian osteopathic profession did not have influential and powerful people with strong social structures to sponsor its professionalisation, as was the case in Britain and the USA.

Osteopathic training was undertaken in privately funded Australian institutions until 1985, when an osteopathic program was established alongside the chiropractic program at Phillip Institute of Technology (PIT). Since the founding of the PIT osteopathic program, osteopathic education in Australia has developed with varying success. Three osteopathic university courses have been established in Australia over the past 25 years – at the Royal Melbourne Institute of Technology (RMIT), Victoria University and the University of Western Sydney (UWS). The UWS osteopathic program was terminated in 2005, and a new program established at Southern Cross University (SCU) shortly afterwards, its first intake being in 2007. Osteopathic programs were established with direction and opinions from a small number of members of the profession and other health care disciplines that were consulted in the accreditation of programs and on external advisory committees. Accreditation procedures had been established by state registration boards between 1998 and 2004 and the development of a national accreditation committee provided some direction

for these osteopathic educational programs. Australian osteopathic education has primarily been developed in universities complementary to other health care education. At RMIT, the osteopathic course was 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, so was exposed to the educational needs of other professions; osteopathy competed for resources with these other programs. Scepticism arose within each discipline, as each profession feared it would be submerged by the others[38, 46]. This behaviour was highly unfortunate and ironic, particularly because with a very similar scope of practice, all disciplines would have benefited from a common curriculum with shared resources[38, 46].

Development of specialised knowledge for the professionalisation of osteopathy in Australia requires interactions and collaboration with other health care professionals. Academic staff within tertiary institutions require collegial relationships in specialised professional domains to establish collaborations 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 allow an individual to construct meaning and work within a social environment like that of a university. Academic osteopaths endeavour to survive in an educational and research environment much broader than that of osteopathy. 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. Habermas and Weber define these social structures as necessary for specific interest groups - in which academic personnel collaborate with the profession, society and government - to provide power and control to be maintained by all[7].

Since the late 1920s, American osteopaths have practiced methods which paralleled those of orthodox medical practitioners, while Australian osteopaths have accepted a drugless practice[38].

Australian osteopathic practice was necessarily similar to that of chiropractic practice, as otherwise osteopaths were unable to practise since they could not obtain registration. Osteopaths have the ability to recommend over-the-counter analgesics and anti-inflammatory medication, but remain much less likely to do so than medical practitioners[38]. Australian osteopaths also debated the use of the electro-physiological therapeutic equipment used primarily by physiotherapists[38], which had also entered chiropractic practice and their curriculum at PIT. Manipulation remained the principal therapy for both Australian osteopaths and chiropractors. The development of education programs for the chiropractic and osteopathic professions at the same institutions had its advantages, cost-effectiveness among them, but ultimately the individual sovereignty of each discipline was compromised, in that both professions competed for the limited resources available.

Currently, Australian osteopathic education is at the equivalent stage of educational program establishment as the American osteopathic scene of the 1940s, 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 1910s, when research funding was provided by the AOA; research funding has been provided by the Australian Osteopathic Association (AuOA) only in recent years. Such funding has been vital in allowing the profession to respond to demands for academic credibility by the public and government[39]. The slow development of autonomous, independent and government-funded institutional osteopathic programs with access to research facilities and funding has reduced the academic credibility of the profession and its existence as a provider of health care in Australia. Abstract and specialised knowledge in Australian osteopathic practice has been limited to general musculoskeletal conditions in private practice. Interactions and collaboration with other health care professionals have been limited to personal communication between individuals in private practice. In Australia, training in osteopathic health care is not undertaken in hospitals, community health care facilities, where research and specialised knowledge can be developed and shared to promote all of the disciplines. Recently, the Australian government has announced funding for clinical

training of a number of health care disciplines, osteopathic clinical training has not been granted any funding[61-63].

Australian osteopathic educational programs have focused on the treatment and management of musculoskeletal conditions, and Australian osteopaths have adopted a generalist approach to providing musculoskeletal health care. Specialisation has not occurred in a sustainable fashion, as no specialist osteopathic colleges or associations exist in specific health care fields (like pediatrics, obstetrics and cardiology). The only osteopathic specialisation that has been attempted is now defunct (the Master of Osteopathic Science degree in pediatrics at RMIT, offered 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 had been established in coalition with that of chiropractic. This linkage was advantageous in providing osteopathy with much-needed recognition, but has also meant that osteopathy in Australia 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[9, 33, 38, 40, 46, 47], unlike in other Anglophone countries.

Contrast between regions

The development of American osteopathy just described illustrates how sociological processes were apparent in its professionalisation. To recap, American osteopathic education began in 1897 with Still, who founded osteopathy and 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 osteopaths as health care professionals occurred with the AOA instituting policies, accreditation and registration procedures. Autonomy and self-regulation professionalised American osteopathy. Growth opportunities were created and decisions made about professionalisation as informed, experienced and qualified individuals representing American osteopathy permeated into all areas of health care policy development and management.

Today, American osteopathy consists of over 60,000 osteopaths, approximately twenty-three well-developed educational programs, and a broad scope of practice in all speciality areas of medicine[8-10]. Osteopathic registration boards and osteopaths exist in all 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 from a sociological perspective reveals that - with respect to abstract and specialised knowledge - it is composed of knowledge based on science and art in areas of orthodox and alternative 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 many associations, academies, insurance companies and research foundations/establishments[64, 65]. The use of propositional and non-propositional knowledge in American Osteopathy is governed by processes of self-regulation and accreditation founded in the legislation of all 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 has been segregated into colleges of the osteopathic profession representing particular specialist areas of health care (such as pediatrics, obstetrics, orthopedics and general practice).

Sociologists like Freidson and Parsons hold 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 values. American osteopathic practitioners are among the most highly paid professionals in the USA[66]. Comparing osteopathic professions internationally, American osteopathy demonstrated the highest degree of professionalism and is a major provider of orthodox health care[8, 10, 33, 39, 48, 49, 67, 68].

Currently seven approved British osteopathic training institutions exist, and there are approximately 5000 registered British osteopaths. Osteopathy is a growing but small profession in the UK (by comparison, the country has approximately 36,000 physiotherapists). Today, there is considerable evidence of the gains in professionalism made by British osteopathy[8, 30, 33, 38, 46, 51, 57, 58, 69], although not yet to the level of American osteopathy. Osteopathic leaders in research and education collaborate with universities, government and health care bodies throughout the UK. The use of informed, experienced and qualified osteopaths is increasing across the healthcare system, and osteopaths are becoming decision makers and managers in greater numbers[8, 9, 30, 51]. Enough osteopaths and educational institutions exist to give British osteopathic education

organisations critical mass in terms of individuals and institutions, as a clarification of management roles has occurred and has allowed policy development.

The current scope of osteopathic practice in the UK 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 and create research opportunities to advance professionalism. The current status of British osteopathy is progressive. Specialist areas of health care are now establishing within the UK osteopathic profession (particularly pediatrics, obstetrics, sports medicine and hospital rehabilitation and general practice)[57, 70-74]. This sociological event is stimulating professionalisation 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 medical programs. This framework provides osteopathic programs with credibility and access to knowledge and research sources for the development (or advancement) of osteopathic practice. The profession is supported primarily by the British Osteopathic Association (BOA), the GOC , insurance companies, the National Health Scheme (NHS) and research foundations/establishments[8]. Processes of self regulation and accreditation are embedded - the profession has representatives in the accrediting authorities[75], 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.

Osteopathy in Australia was relatively slow to develop abstract and specialised knowledge compared to its UK and US counterparts. Nevertheless, knowledge in the science and in the art of musculoskeletal health care has now 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. Simultaneously, poor access to knowledge and research in osteopathic practice within universities has limited the profession's capacity to develop (or advance) professional abstract and specialised knowledge. As a result, research has had marginal impact on the direction and scope of Australian osteopathic practice, and in providing osteopathy with authority in the musculoskeletal health care area. The Australian 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[76]. Currently, legislation for the regulation of osteopathy exists in most Australian states and territories, and in those states and territories where specific legislation does not exist, osteopathy is incorporated in legislation that regulates the practice of chiropractic[9, 33].

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

Proposal for direction in research

History has shown that society needed science to deal with the actions of bacteria, parasites and viruses in the causation of chronic disease and acute health care conditions. Scientists and scientific knowledge supported the medical model that led to a near-monopoly of health, status, income and public financial support for medicine; occupations allied to medicine also benefited. In recent years, there has been a growth in non-orthodox medicine and the concept of medical pluralism[11]. Due to the decline in the impact of infectious diseases and improvements to water supply, sanitation and the environment in more developed countries in the nineteenth and twentieth centuries, the perception of health has shifted from the earlier view which emphasised the eradication of disease by biomedical means to an emphasis on the social and economics determinants of health[11]. Both society and health care have experienced the effects of feminism in all sectors and domains of the community[11]. A decline in mortality at all ages corresponded to an increase in average life expectancy from birth and an ageing population; the latter means that the prevalences of most chronic disorders have increased. Major changes in the modes of health delivery and the organisation of health care have occurred - doctors can make decisions regardless of cost[11]. Today, hospitals are not seen as major providers of health care to the same degree as in the 1960s. Professional autonomy and self regulation are subject to greater external scrutiny[11]. For the professionalisation of osteopathy in Australia 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.

In the 1980s and 1990s, increasing proportions of Australian health services were provided by the private sector. An increase in private hospital demand allowed the private sector to profit from the treatment of health conditions by reducing costs, providing better services, increasing turnover of patients and increasing competition between the private and public sector[11]. Health care became a commodity and patients became consumers. Consumer demand for private health increased, with simultaneous rises in 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 organisational processes[11] between the private sector and government; a new level of organisational development known as the meso-level was established by government and health care providers. This level is defined as an intermediate layer of management and administration in society 'where policy and organisational and managerial processes tend to be concentrated' that relate to health policy and organisational theory[11]. It is at this level where privatisation 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 organisations are becoming increasingly prominent in the meso-level of society in contemporary health care[11].

Meso-level management and government has been increasing the demand for research that validates and demonstrates a profession's effectiveness in the health care system. Lay knowledge is producing health care policies based on outcomes or evidence based research by linking social and biological factors in the management of illness and disease. Cost effectiveness is a major issue for the health care system due to the cost of chronic illness, particularly musculoskeletal disease, which currently ranks as the third-most costly Australian disease category[42]. The Australian Institute of Health and Welfare illustrates the current health needs of the community, and how outcomes based policies are being adopted and implemented by government, institutions and organisations that need to be considered in the current and future professionalisation of osteopathy in Australia.

This article reports on the gaps in the advancement of Australian osteopathic professionalism, and the author provides an argument based on literature on how these gaps can be addressed in advancing osteopathy's professional status.

The Australian osteopathic profession is in a privileged position to test the bounds of evidence-based and complementary medicine. An enhancement of its professional status would result, as its educational curricula and scope of practice would be informed by evidence-based orthodox and

complementary research. It is apparent that similar problems have plagued other professions (such as physiotherapy) in Australia, the UK and USA, The relatively successful American and British osteopathic professions have relied upon factors like the number and type of practitioners, the research profile of the profession, the educational institutions and opportunities, and the informed management decisions undertaken in meeting the needs of society and developing knowledge in specialised health care. These mechanisms and resources have been instrumental in their osteopathic professions expanding and becoming significant stakeholders in primary health care.

American medical and osteopathic professions have progressed independently by establishing registration boards and professional education in universities that integrated with the missions of the government and tertiary education providers. Their professions were established through specialisation, quality assurance and research strategies to support professionalisation. American medical and osteopathic graduate attributes have been integral to the advancement of these disciplines. Early American medical opposition to the acceptance of the osteopathic discipline acted as a catalyst to improve osteopathy, such that both groups governed their own advancement relatively independently. The situation differed to an extent in the UK. The UK and Europe accepted complementary health care, and provided enabling environments for osteopathy to establish itself. The slow regulation of UK osteopathy may have been the result of a lack of medical opposition. As numbers of osteopaths increased, some became leaders in research and education; when registration eventuated in the UK, the osteopathic profession had well-informed, experienced and well-placed individuals ready to accept the roles required for the advancement of the status of osteopathy.

The small number of Australian osteopaths and correspondingly limited resources may seem like a hindrance to the advancement of Osteopathy in Australia. This may be only a short term issue and may even be advantageous in forcing the profession to collaborate with other stakeholders in the health care system and develop a professional rational and united voice in a health care system in which the number of osteopaths and osteopathic resources can increase. Anecdotally, every

graduate that has completed an osteopathic professional program in Australia has gained employment. The Australian osteopathic profession is well placed in providing health care services for an increasing and ageing population and providing the ever increasing demand for musculoskeletal and specialised health care and research.

Proposal for direction in research

This report reviews issues that affect in the context of health care provision by professions including osteopathy. Overarching concepts emerge in this report from the analysis of sociological issues that affect all professions. This report provides a conceptual framework for defining the current professional status of osteopathy in Australia and identifying gaps in the research literature relating to professionalism. A qualitative research approach and method would be applicable to collect and categorise data from the osteopathic profession and its members in Australia, based on Freidson's principles of professionalism.

The professional characteristics of Australian osteopaths are important in identifying the current standing of the profession with respect to abstract specialized knowledge, autonomy, self-regulation, authority, and altruism as Freidson sees as necessary for professionalism.

Views of Australian osteopaths on the professional status of osteopathy with respect to practice issues that affect the status of the Australian osteopathic profession are important in identifying gaps and in developing strategies to advance of health care practice and delivery. An assessment of issues like gender, medical dominance, education and research in the advancement of osteopathy in Australia are important.

Key informants' perception of the current status of Osteopathy in Australia compared to the profession as a whole are worth investigating as these informants clarify the current status of profession and how any gaps can be and are being addressed based on criteria of professionalism as defined by Freidson.

Strategies can then be subsequently established and adopted to focus on advancing the professionalisation of osteopathy in Australia.

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