# Professional Project and the Evolution of Non-Dominant Medicines
## -The Case of Osteopathy and Chiropractic-

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This article explores how non-dominant medical practitioners shape their own self-images and the identity of relevant medicine and in what ways fashioning of self-images and accompanying modalities of medical practice informs the social evolution of the medicines at specific times and over specific places, by means of the historical configuration of osteopathy and chiropractic in the UK and the US. Attention is directed onto motivations and pursuits for professional recognition and actual strategies and activities of non-dominant medicines and its practitioners by turning to historical instances such as osteopathy and chiropractic in the UK and the US, not least drawing focus on professional desires with regard to circumstances it faces within and without.

Some non-dominant medicines as a way with which to acquire and protect the exclusive monopoly of its knowledge and practical skills, adopted various forms of professionalism project, as dominant biomedical groups pressed up non-dominant medicines by virtue of marginalizing tactics. Meanwhile, non-dominant medicines took somewhat distinctive professionalisation strategies from each other. Strategies they took were diversified depending on medical philosophy, healing modality, the degree of occupational solidarity embodied as forms of medical organisation, and especially vocational aspiration and prospect. Change of socio-medical culture and the state's policy seems to have wielded critical influenceon the determination of the ups and downs of non-dominant medicines. From the perspective of long-term time span, dominant biomedicine eventually did not have much influence on the ups and downs of marginalized medicines in so far as in the case of osteopathy and chiropractic in Englandand the U. S.

**Keyword** : osteopathy, chiropractic, professionalisation, professional project, complementary and alternative medicine

## Ⅰ. Introduction

When it comes to discussing the matter of professions, as might always be the case, one of the instantaneous challenges is certain to be the problem of definition. Literally, the term of profession refers to "occupational group, characterised by claims to a high level of technical and intellectual expertise, autonomy in recruitment and discipline, and a commitment to public service" (Jary and Jary 2000:489). However, a difficulty posed is that such a routine definition is not able to answer the specific question of "which occupations should be called professions, and by what institutional criteria (Freidson 1983:21)" in actual settings. Thus, as far as the topic of this thesis is concerned particularly with medicine - one of traditional learned professions, it may seems that a pragmatic way to eschew the dilemma of such kinds is first of all to review on a temporally sequentialbasis definitions and related theories that have been presented by major academics around the study of professions, and then to take syncretically those

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definitions and theories as exploring one or more of various features of professions, and on the other either accounting for historical and geographical changes of the substance of professions or responding to the social representation of a particular profession made by itself or imposed by others. It may be that the virtue of such approach lies in the fact that diversified yet seemingly incompatible views "relate to [or reflect: added] different professions at different points in time [and place: added] and also that contradictory processes···exist in the development of any single profession" (Johnson 1972:17).

The phenomenon of professionalisationwas first observed and analysed by the English writers like Carr-Saunders and Wilsons. They charted characteristics of occupations that were customarily considered profession and extracted essential traits of true profession, which included esoteric knowledge and skill, occupational association, training and credentialing, ethical codes of conduct. They in turn utilised such traits as a measure with which to judge the degree to which other occupations had reached. Functional approach emphasized positive functions of a complex body of expertise and its accompanying organizational process for society's sustenance and assumed that the phenomenon of profession be taken for granted. This consequently led to failing to recognize political aspects indispensable to capturing profession as a kind of occupation within a sociopolitical division of labour; professionalism as an occupational ideology; and professionalisation as an occupational project(Abbott 1988:4).

From the early 70s, some academics moved their research orientation toward how professions do what for the purpose of negotiating and upholding their special positions, away from on crystallisingcharacteristics of socially established professions in the 60s. This lines of research is known as influenced and stemmed primarily frominteractionist Becker and Hughes. They saw the institution of professions not so much as from deriving a body of intrinsic natures of such particular occupations like medicine, lawyer or clergy, but as socially negotiated or contested one. By doing so they opened up veils surrounding profession's work and exposed the performance of everyday work on the spot (Freidson 199:42 and Saks 2000:224).

Based on the assumption that "professions are collective human enterprises as well as vehicles for special knowledge, belief, and skill" (Freidson 1970: x vii), Freidson brought to light ideological aspects of professional claims with regard to specialised professional knowledge and skill, monopoly of occupational privilege, and the way professional bodies create and sustain authority(Freidson 1994:3). He also explored how institutional positions of profession influence on the production and application of knowledge/skill and the way some of occupations differentiate themselves, acquire and maintain the position of profession within social division (Freidson 1986: x i ). He highlightedthe role of government and argued that professional autonomy as a reification of the power of profession ultimately depends on the power of the state. Accordingly it is not surprising that such nuanced terms as 'dominance,' 'power,' 'autonomy,' or 'ideology' frequently appeared on his works. as Macdonald put it, "with this shift in emphasis from structure to action the sociological question changed from 'What part do the professions play in the established order of society?' to 'How do such occupations manage to persuade society to grant them a privileged position?' (Macdonald 1995: xii).

Parry and Parry(1976) focused on the salience of occupational associations and organisations in the control of professional market and traced professions as a middle class being located in a wider context of collective social mobility in modern societyby using the historical evidence of medicine as the English middle class (1976:1 and 18), as Larson would do one year later. While they acknowledged Johnson (1972)'s contribution to the accentuation of the actual process of professionalisation in terms of power and control; and its rejection of any conceptualisation of "an automatically unfolding development of professional specialisation" on wholly 'rational' principles, " they criticised his thesis to underline consumer's dominance as a primary determinant of professionalism in changing power relationship between producer- consumer in modern capitalist society. Instead, they proposed "the relationship between colleagues···and professional associations which··· enable control over the supply of professional services to the market" as a main collective variable in thefuture of

professions (1976:43). Relying on Giddens' structuration theory, they suggested that combination of professions and the position of middle class is "not merely the coincidence of class and status group membership···but the active creation of organisations and associations which themselves serve to implement an occupational strategy which embodies the explicit idea of controlling the market for particular goods and services." occupational groups are geared up for the control of market, which involves collective action for collective control and attempt to ultimately obtaining "an officially conferred legal charter" (1976:59).

Larson (1977) also explored the very process by which professions emerge from the perspective of a social project - collective social mobility, turning to socio-historical study of their life course and the environing socio-economic settings. With reference to the control of market she also investigated ideological as wellas economical function of the model of profession as a social institution.

> "Professionalization is thus an attempt to translate one order of scarce resources -special knowledge and skills - into another-social and economic rewards. To maintain scarcity implies a tendency to monopoly monopoly of expertise in the market, monopoly of status in a system of stratification. The focus on the constitution of professional markets leads to comparing different professions in terms of the marketability of their specific cognitive resources···. The focus on collective social mobility accentuates the relations that professions form with different systems of social stratification; in particular, it accentuates the role that educational systems play in different structures of social in equality" (Larson 1977: x vii).

According to her, the social configuration of professions derives from the conjunction of the evolution of professional organisation aiming at the market of service and the advance of collective social mobility for status and social standing. All the devices and rhetoric being exploited for a professional market and professional bodies were once again incorporated into ideological supports as resources for profession's drive toward social respectability and standing (Larson 1977:66). This is the point where "the model of profession passes from a predominantly economic function - organizing the linkage between education and the marketplace - to a predominantly ideological one - justifying inequality of status and closure of access in the occupational order" (Larson 1977: x viii).She also illustrated that the state, not least in England and the Unites States in the nineteenth century, conditioned 'professional modernization as a project of market control' by means of sponsoring monopolistic education systems (Larson 1977:18). She showed that the distinctive constellation of organization, resources and strategies enabled members of occupational association to advance professional project as both a model for the market of service and a lever for upward social mobility, within the newly emerging socio-economic milieu in the nineteenth century (Burrage 1990:3).

Since the eighties, there is a sense in which various endeavours have been made to bind historical and sociological perspectives so as to illuminate intraprofessional or interprofessional variations over time and places. Larkin(1983) is interested in the way in, and the extent to, which one profession impacts and shapes adjacent occupations in terms of quest, tactics and consequently prospective fortunes, with reference to inter-occupational domination, which is the same theme and perspective as Abbott's below. Empirically, by using the concept of occupational imperialism, he examines the process in which dominant medical professions controlled or scrutinised other para-medical occupations - opthalmic opticians, radiographers, physiotherapists and chiropodists in the United Kingdom - who were pursuing their own professional project involving autonomy and market control and the latter, in reverse, moulded their desire and tactics against the former and at the same time had to negotiate boundaries with each other(Larkin 1983:1). From his study, he concluded that an occupations is, from a general level of analysis, positioned within historically demarcated boundaries in the division of labour by two major forces a dominant profession as external force - occupational imperialism - and an internal imperative of subordinate incorporation as a realistic stratagem (Larkin 1983:198). While the state and medical profession preferred hierarchically ordered divisions of labour and undoubtedly succeeded in controlling the division of labour, nonetheless para-medical groups were also, though in part, successful in influencing the dominant medical profession to shift from one form of domination to another

in order to face changing contingencies. In other words, it may as well say that it is rather the outcome of a process of changing interplays derived from the competing stratagems of occupational groups in a specific power landscape involving the state (Larkin 1983:22).

As for Abbott, like many writers since the 70s, his general interest concerns the process in which professionalism take places as a type of institutionalisation of expertise - speicialised knowledge and skill - in modern society; and "the evolution and interrelations of professions and···the way occupational groups control knowledge and skill" (Abbott 1988:8). However, in that he preferred the observation of intraprofessional process at a micro level as well as interprofessional course at a micro level, he is distinctive from other writers. He employed the concept of 'system' - the system of professions - in a view to emphasise relational or interlinked aspects in the structured constellation of adjacent professions. He highlighted that within the magnetic force of structured interplay of neighbouring professions, fluctuations in one position affect others, redefine them and in full circle adjust itself and then analysed micro-differentiation within a profession in combination with 'system conditions' as well as with reference to larger social forces in terms of its impact on individual professions(Abbott 1988:315). It is followed that his main theme is centred around jurisdictional claims and interprofessional competitions as well as the underlying conditions and environments of the control of expertise(Abbott 1988: x ii - x iii and Freidson 1994:7).

> The central phenomenon of professional life is thus the link between a profession and its work, a link I shall call jurisdiction. To analyze professional development is to analyze how this link is created in work, how it is anchored by formal and informal social structure, and how the interplay of jurisdictional links between professions determines the history of the individual professions themselves (Abbott 1988:20).

In short, he explores the life course of professions - the way professions grow, spilt, join, adapt and die in the ecology of internal and external - in cultural and political environments through a microscopic lens.

According to Saks (2003:224-225), participants in a profession seek to control occupational boundary in their favour and restrict access to the profession's jurisdiction. Occupational groups try to produce and secure their interest-based territory, or professional boundaries - flexible and constantly changing - by social closure through various ways, whether practical or intellectual. Two main forms of social closure are usurpation and exclusion (Parkin 1979 in Saks 1998:176) and social closure in medical arena takes the form of professionalisation. Several groups of heteromedicine[1] are seeking to become integrated into the formal healthcare system by way of professionalising themselves. Their efforts and the popular support for heteromedicine is a big challenge to conventional hierarchy of the established medicinal world centred on biomedicine, and are bringing about a variety of demarcating responses from the established medical profession. Dominant medicine reacts to heteromedicine's professionalising efforts by mobilizing a series of strategies in order to contain the acceptance of heteromedicine groups like 1) insisting on the scientific evidence of safety and efficacy 2) resisting to the integration of heteromedicine with conventional medicine by means of co-optation 3) gate-keeping and rejecting team work and opposing government support for research and education(Kelner et al. 2004). Heteromedicine as a counterpart of biomedicine mobilises several strategies to professionalise. The strategies are related to how the knowledge base is organised and transmitted. These strategies include 1) improving educational standards; 2) improving practice standards 3) engaging in peer-reviewed research increasing group cohesion(Welsh et al. 2004) and 5) producing authoritative and certified knowledge(Sharma 1992).

Varied groups in heteromedicine, meanwhile, show striking differences in attitudes, depending on the extent of formal organization of respective groups, and beliefs in the importance of demonstrating effectiveness, safety and cost-effectiveness in a rigorous scientific manner. Not all the groups within one health care occupation does participate in the professionalisation movement and undertake rigorous research. The more formally organized heteromedicine

1) In this research the term 'heteromedicine' is used instead of 'complementary and alternative medicine' to indicate sociological symmetry

groups, the more likely they are to recognize the importance of scientific research on their practice and therapies (Kelner et al. 2002 and Sharma 1992).

# Ⅱ. Discussion

## 1. Professions and the State

Professions by nature pursue the monopoly both of their knowledge base and the provision of services in the market; and autonomy in the control of their work being insulated from outside influence. However, such monopoly and autonomy arenecessarily bound to be in conflict and incompatible with free market system in the modern world, and the privilege of monopoly and autonomy can only be endorsed and granted by statutory or administrative control. Accordingly it is the point where professions are distinctively linked with thestate. They are dependent on 'the coercive power of the state' (Freidson. E. 2001:128). Thus, examination of the interplay between professions and the state necessarily constitutes a main part of the study of profession(Kelner et. al. 2004:80). Freidson specifies the relationship between professions and the state as follows.

> "It is the state that has the power (1) to officially define and classify particular kinds of work in the labor force; (2) to permit and support the occupational constitution of a division of labor and abjudicate jurisdictional disputes within it; (3) to defend labor market shelters against both labor consumers and would-be competitors; (4) to legitimate the connection of vocational training with officially classified higher education and to accept and support the credentials it produces; and (5) to give credence to the professional ideology. Furthermore, the state creates and maintains general educational system which provides the foundation for professional schooling. In sum, it is the key force required for the creation, maintenance, and enforcement of ideal typical professionalism" (Freidson 2001:128).

In brief, the state is the prime contingency for the socio-economical institution of professionalism (Freidson 2001:128).

However, it should be noted that the relationship betweenthe state and professions varies in different times and places in connection with diverse details of socio-political and historical power networks as well (Macdonald 1995:67). By and large, continental states in Europe were more proactive and took the initiative in health care arena or in some instances even directly organised training, service provision and market control (Freidson 1983, 2001 and Macdonald 1995). In colonised regions during the imperialist period therelationship of the state to profession was to be marked by different features from those in Western states as well. In the case of the former British colonial territories, statutory protection was not the result of professional mobilisation, but rather the outcome of state involvement (Johnson 1972:29) and furthermore medicine was incorporated into administrative apparatus(Macdonald 1995:116). In the colonial Korea and Taiwan, colonial regimes utilising the ideology of modernisation disregarded old culture of specialised occupations and coercively and revolutionarily carried through the institutionalisation of professions modelled upon a perceivedly modernised Western form, even by means of mobilising military police as one of effective administrative machinery (Lo 2002).

As the formative period of modern Britaincan be distinguished largely by a cohabitation of the old regime and rising bourgeoisie involving the balance of power, autonomy and self-government and others, the course of professions was also characterised by such identical features. Control of the professions was kept on a minimum level and candidates for professionalism regulated themselves and statutory or chartered powers were granted to them with lower level of regulation by the state. These circumstances can be viewed to be a precondition for theemergence of what can be considered as professional project of the kind approaching ideal typical type of it (Freidson 1983:24). Medicine in Britain enjoyed the self-regulation of education and training as a key mechanism of check over the number of members of a certain profession. British professions have held pluralist and autonomous features inherited from the pre-modern period while state regulative intervention infiltrated into medical professions and organizationthough this is the case proportionately later than in other nations. It follows that "although the medical profession is clearlylinked to the state, there is considerable autonomy

for their organizations, which retain forms and practices that goes back to the Middle Ages" (Macdonald 1995:78-79).

In Britain, the expansion of the state's involvement in health care such as promulgation of the National Insurance Act or introduction of the National Health Service from the early half of the twentieth century onwards did not temper monopoly and autonomy pre-emptedby medical professions. On the contrary, it provided, or functioned as, opportunity for medical profession to consolidate medical market and professional influence by means of expanded scope of patients (Macdonald 1995:107). By and large, situation in the Unites States is seen to have been the same in England.

> While everyday practice may or may not be different under these systems, they have not changed the fundamental strategy by which the profession has tended to pursue its interests since the mid-nineteenth century. The profession has simply developed more effective tactics and administrative relationships to make use of the increased potential for interest satisfaction in its relationship to the state. In retrospect, the liberal threat to the existence of the medical profession ironically resulted in institutional changes which, though unanticipated, improved the interest position of the profession once the state began to play a significant role in distributing services to the nation (Berlant 1975:174 in Macdonald 1995:107).

On the contrary, situation in continental Europe was quite different from those of the Anglo-American territories (Freidson 1983:25). In France, salience of the state power features in relationship between the state and professions. The state, from the period of the Ancien Régime through the French Revolution through until recently, has preserved the centralised form of polity and state officials have been able to exercise enough power to control and reshuffle professions andtheir organisation, which is seen to be distinctive from the pluralist instance of Britain. It therefore followed that the state's direct charge of health services and medical education induced the vulnerability of professional associations. Medical education and examination was under the jurisdiction of individual academic professors rather than the professional organisation. As a result there coexisted a number of various representative groups indicating respectively their disparate positions in medicine (Macdonald 1995:89).

In Germany, the system of profession is characterised by the direct control of professions by centralised political power, the structured weakness of professional groups, the prosperity of professional knowledge and skill itself, and the early introduction of health insurance. It is until the nineteenth century that numerous local governments of small size had divided and ruled the present German territory. It means that therewas no centralised coercive or administrative power to control professional organizations on a national basis, though local administration was highly strong and absolutist. Local powers competed for higher education at the university level as a symbol of their prosperity. The culture of 'the educated middle class' (Jarauch 1990; Huerkamp 1990) endorsed prosperity of universities and antipathy against commercialism. This was also responsible for the comparatively late development of market-oriented professional associations and advancement of theoretical medical knowledge and skills in Germany. With regards to medicine, since the emergence of the relatively united Prussiaand the successive German Empire in the nineteenth century, in the hands of the state has lied the enforcement of medical education and practice registration in Germany, while they were one of crucial ways for medical associations to control members in Britain and the United States. This necessarily meant that the enlightened absolutist state administration played a main determinant in medical arena and professional bodies accordingly failed to control medical training and professional admission (Jaruach 1990; Huerkamp 1990). As in France, due to the state's intervention in hospital organisation and medical education at the university level, a pool of medical knowledge and concomitant academics grew up rapidly around universities. Yet it should be noted that it did not lead to mean the empowerment of medical associations and professions in the German case. Doctors were required to report to medical authorities on a regular basis though they were not civil servants (Huerkamp 1990:77). Siegrist terms profession in such a condition 'state professions' (1990).

In that the process of professionalisation is mediated or even controlled primarily by the state's power, the state is the most powerful external parameter in theevolution of professions. However, the influence of the state varies over a particular time and space in terms of force and

will in relation to the institutionalisation of profession as a social division of medical labour.

> The state' s power, even when despotic, may at different times and in varying circumstances be exercised by a monarchy, his ministers, their administrators, by other elites such as the military, and so on. The same is true of other socialactors, such as parties - or professions - whose policies and strategies are not pursued in a consistently purposeful way (Macdonald 1995:100).

## 2. Landscapes of Health Care and Non-dominant Medicines in the 20th Century

In this section, attention will be directed onto motivation-sand pursuits for professional recognition and actual strategies and activities of non-dominant medicines (NDM) and practitioners by turning to historicalinstances in both East Asian countries and western countries, not least drawing focus on professional desires and a legitimised kind of knowledge production with regard to circumstances it faces within and without. With the booming of interests in marginal medicines in terms of both consumption and provision, social scientists from varying backgrounds have engaged in this area and as a result considerable amount of study has accumulated as to social and economical conditions that engendered thegrowth of non-dominant medicines. Nonetheless, much work have not been done in depth regarding how practitioners of non-dominant medicines locate themselves in changing health care terrains and what to choose to do for occupational aspirations, especial with reference to the production of formalised knowledge claims as a assumed prerequisite for entry into publicly recognised professional status(Kelner and Wellman. 2000:3).

Interests in, and the extent of, professionalisation in NDM with regards to institutional arrangements and the production of pertinent knowledge claims vary depending on each group' s motivations and strategies and surrounding environments. It is intertwined internally with each group' s prospective desire, 'a level of development of organizational *unity, codes of conduct and educational standards*' (Saks 2000:229) and externally associated with influential biomedical bodies, changing state policy and regulation, and expanding consumerism in the market. In such environments, a significant number of NDM groups, though to varying degrees, have followed distinctive professionalisation projects no less as an active strategy for obtaining legitimacy than as a reaction against the backcloth of the competing medical profession, the state' s policy, and changing market. Even within one NDM boundary, there exist meanwhile diversified positions towards professionalisation and accompanying requirements depending on socio-medically located contingencies and philosophies on human-medicine relationship.

Medical profession not only took place as a model of market control andoccupational type first in the Anglo-American capitalist territories but also firmly secured its ascendancy thereafter through politico-legal victory under the patronage of governing bodies. So the dominant and the marginal medicines in Britain can be seen to showcase the typology of orthodox medicine and marginal medicines in the recent centuries. Medicine in Britain, since the second half of the nineteenth century, has been marked primarily by the Medical Registration Act of 1858 and the existence of various practitioners outside medicine by the Common Law, which is seen to be a compromise between the medical profession pursuing absolute market monopoly and the British liberalism disposed towards anti-monopoly.This compromise "provided for a number of institutional changes not strictly in keeping with the profession' s traditional monopolization strategy of legally privileged restriction and professional autonomy" (Berlant 1975:167). To the English medical profession, the Registration Act gave thedecisive occasion where they could consolidate ever strongly and firmly their dominant position by securing a unified register of statutory recognised practitioners, self-regulation, control of educational system, furthermore by monopolising exclusively the title of 'doctor' and state medical employment (Waddington 1984 in Saks 1999:129; Saks 1992:5; 2003:37; Saks and Lee-Treweek 2005:82). Meanwhile, This compromise enabled practitioners outsideregistered medical practitioners to keep on performing their modalities under the Common Law(Saks 1992:5) "as long as they did not represent themselves as medical practitioners" (Saks

2003:38). Viewing socio-medical role played by this negotiation from wider standpoint of politics, however, this legislation has thereafter functioned as formal delimitation of the boundary drawn between orthodox and non-orthodox medicine and enabled the dominant medicine and the allied government to marginalize, and to significant extent make invisible from the public eyes, alternatives to the authorised medicine.

The National Health Insurance Act of 1911 and the National Health Service Act of 1946 further reinforced virtual monopoly by 'medico-bureaucratic project(Larkin 1995:50)' by a alliance of the medical profession and the state, as they confined the delivery of expanded medical provision to legally qualified medical practitioners and denied non-registered practitioners opportunity to take part in sharing broadened potentialities (Berlant 1975; Larkin 1995:47-48 and Saks 1999:130). Medical practitioners' monopoly of national health provision scheme - marked by the National Health Service(NHS) - and exclusion of medically unqualified practitioners had profound impact on the fate of non-orthodox medicine in Britain in terms of its provision availability and the public's accessibility. This was attributed to the historical framework where it was only through medically qualified doctors that patients could get access to all the state-providing health service(Huggon and Trench 1992:241-245; Macdonald 1995:107; Saks 1994:86). Consequently these enactments levered up the medical profession on a virtually unsurpassable position among various health providers(Parry and Parry 1976:208, 212 and Saks 2003:49;71) and in the meantime heterodox healing modalities were decisively marginalized from medical arena as heterodox practitioners were legally excluded from public medical service and confined to within private sector (Saks 1994:86-88). Their habitat was further deteriorated by thelegislations that imposed non-registered practitioners restrictions or prohibitions on claims to treat serious conditions ranging from cancer to diseases such as cataracts, diabetes, epilepsy and tuberculosis (Larkin, 1995:51 and Saks 1999:130).

After having established the effective monopoly of medical practice, the medical profession in Britainfurther consolidated its medical dominance through the containment of medically related occupations other than medicine itself by means of mobilizing three distinctive strategies such as limitation, subordination and exclusion (Turner 1995:141). Limitation strategy was applied to pharmacists, dentists and opticians, which professions obtained their autonomy from direct medical supervision but at the cost of acknowledging strictly confined jurisdictionsof a specific scope(Larkin 1983:58-59); subordination interface was manifested in the cases of nursing and midwifery(Saks 2003:60); exclusionary activities were employed against medically non-qualified therapists who rejected subordination to medical supervison and was denied formal registration, as in the instance of osteopaths(Larkin 1992 in Saks 2003:52-53). It is said to be one of factors that contributed to the situation where heterodox therapies had remained virtually invisible in both public and private sector with this marginal exclusion by the1950s(Saks 1995 in Saks 2003:72).

However, sweeping generalisation may well lose its legitimacy. As far as evolution in the structure of health care provision is concerned in Britain and the United States, there has been a misconceived myth of the sameness that hampered to recognise differences between two countries(Macdonald 1995:79). For all the similarities of regulatory arrangements in general, local or national contingencies in the 20th century however primarily made distinctive the trajectory of interrelations between the ascendance of dominant medicine and the fate of alternative modalities being marginalized in the United States, in so far as one focuses on theevolution of alternatives to orthodox medicine. That was implicated with ever-strong anti-monopoly culture(Berlant 1975:234-247 and Starr 1982:100), diversified judgement of local judicial courts associated with geographically disparate needs, therelative absence of collective medical organisation and a internal fragmentedness of the professional structure (Starr 1982:92), and in particular the different structure of governing system involving the regulatory mechanism of health care provision in theUnited States. Relatively more decentralised political configuration generated regulation or legislation legitimising alternative curing modalities to orthodox medicine depending on each state's environment rather than on a national basis, as indicated by thecase where osteopaths had gradually

gained their independent licensing laws in a majority of states since osteopaths was first in 1897 given legalisation by the Missouri legislature(Starr 1982:108; Saks 2003:39, 78 and 84). Even before obtaining separate legal licensing board, osteopaths and chiropractics were seldom prosecuted for illegal practice or favourably adjudicated by the local judiciary in spite of protest from the dominant medical practitioners. It was arguably because they provided primary health care needs in rural areas and the press was favourably disposed to the prosecuted and called for tolerance as well(Starr 1982:100). These are viewed as major factors that some heterodox medicine in the United States, if not all, were more successful in professionalisation both in terms of time and extent, compared to those in England, though under the general trend of an unprecedented consolidation of dominant medicine in both sides of theAtlantic. Meanwhile, the American tradition of frontier medicine and private health care also enabled alternative practitioners to establish their own relatively strong organisation and social niche in modern times(Wallis and Morley 1976 in Saks 1992:1). In face of such socio-political challenges the medical profession in the United Statesbegan to take a more incorporatist strategy towards heterodox medicine than counterpart in England from the middle of the 20th century(Starr 1982:100-102 and Saks 2003:88).

## 3. Professional Quest and the Evolution of Osteopathy and Chiropractic

In both countries of the UK and the USosteopathy and Chiropractic are seen as the most professionalised among non-dominant medical practices(Gevitz 1988b:155). However, the way and extent that they reached professional status are highly different between two countries, especially depending on statutory regulation and the nature of medical profession they faced. What is more, they took divergent passage from each other within one country as well, depending on internal features they retained and strategies they took up. Osteopathy and chiropractic in the US followed, to a large extent, different avenues from each other and both of them also from each counterpart in Britain in relation to professionalisation. It seems to be a rare case in the history of non-orthodox medicine that osteopaths in North America have reached professional status equivalent to that of medical physicians by way of a form of gradual incorporation and partial merger with the dominant latter, ending up functioning as 'parallel practitioners' (Weitz 2004:376); yet within osteopathy have remained some of distinctively different ideas and practices about health and sickness from medicine.

It was Andrew Taylor Still who, compounding concepts and philosophies of 'magnetic healing' with 'bonesetting' founded the underlying ideas in osteopathy that dislocated bones - especially of the vertebrae - obstruct the smooth flow of blood causing consequently various kinds of unwellness in human; and so restoration of displaced bones is indispensableand fundamental for the removal of roots of disease. From its initial stage of development, the American Osteopathic Association (AOA), established in 1897, was proactive towards acquiring professional status.

> From its inception, the AOA actively worked to secure the conditions necessary for the movement to obtain professional recognition. It fought for independent boards of registration and examination to give the profession autonomy; it significantly lengthened the standard course of undergraduate training and supported ongoing research projects; and it championed a code of ethics while combating the growth of impostors and imitators (Gevitz 1988:132-133).

By the third decades of the twentieth century osteopathic education set out to establish the same standard to that of medical colleges in mandated period of training, and almost all of the states granted official license to osteopaths. However, in many states osteopaths were bound to limited entitlement and had to go through a assessment of biomedically relevant sciences administered by licensing authorities controlled by dominant biomedical bodies(Weitz 2004:377). Despite of contrasting philosophy and medical modality however, with the pursuit of institutional innovations, osteopaths incorporated biomedical courses and even went further to directly make use of biomedical textbooks in a view to expanding the scope of treatment as a means to cope with biomedical practitioners, including prescription of all kind of drugs, surgery, obstetrics and gynecology, emergency medicine and the like (Coughlin

2001:108). Unsurprisingly osteopathic colleges gradually approached medical schools in terms of inner contents and attributes as well as visible institutions. A symbolic case manifesting attitudes of osteopaths with regard to relationship with biomedicine is the event where dissension around vocational orientation and incorporation of biomedicine led to break-up of the AOA from Still, its founder. More climactic event of this procession is said to be the merger of the Californian Medical Association and the Californian Osteopathic Association in the 1960s. This resulted in the rise of state-underwritten osteopathic colleges and the standing adjustment of osteopaths to an equivalent to medical professions in professional privileges. Most of California osteopaths made the incorporation bargain with the medical profession in California, involving switching over their osteopathic degrees to a new medical degree, transforming the California osteopathic hospitals and educational institutes into biomedical establishments, and the state' s abolishing osteopath license (Saks 2000:232; Weitz 2004:377-378). This merger motivated most of thestates to grant unlimited autonomy to osteopaths across the country at a state or federal level and in turn brought to osteopaths the insurance coverage of osteopathic treatments equal to that of biomedical practices (American Osteopathic Association 2002 in Weitz 2004:378). By now osteopaths in Unites States have obtained professional privileges by way of making full use of partial incorporation and merger with the dominant medical profession. They are enjoying virtually the same privilegesin training and hospital to those of medical practitioners and interacting with the latter on an equal basis. Meanwhile, it should be noted that as initial differences between medicine and osteopathy in theory and culture gradually dissolves away, osteopaths' sense of separate identity and internal solidarity alike are also fading away while ties with medical doctors grows steadily. Accordingly, an unavoidable issue is posed-that of unique identity and raison d'être. Osteopaths have gradually distanced themselves from the original practice of manipulation of bones and in turn preferred the title 'osteopathic medicine' rather than 'osteopathy' and 'osteopathic physician' rather than 'osteopath', bringing about an dispute concerning identity and prospect as a distinct profession from medical profession (Coughlin 2001:108). This case may be seen as an evidence indicatingthe paradox where marginal professions is bound to be situated when they take incorporation and merger with an dominant profession as a strategy with which to achieve professional status identical to the latter (Weitz 2004:379).

In contrast to osteopathy, chiropractic in the country won professionalisation by means of taking a distinctively different socio-political course from that of the former - keeping original philosophies and treatment modalities of its own and resisting to medical profession' s medicaland political hegemony, although those two look to a great extent similar to each other in terms of basic elements in theory and treatment on their early stage (Saks 2000:232; Coughlin 2001:111). Chiropractic was founded in 1895 by Daniel David Palmer and thereafter developed further in size by his son, B. J. Palmer. Chiropractic viewed spinal dislocation as the cause of illness mediated by disturbance of nerves while osteopathy attributed illness to the mal-circulation of blood obstructed by disarrangement of bones, in particular of vertebrae. It seems no wonder that there has been the rumour that Palmer was a patient of Still (Coughlin 2001:111; Gevitz 1988b:168). However, chiropractors were more disposed to embrace holistic vitalism - that is responsible for chiropractors' strong dislike of drugs and surgery and, for the same reason, of biomedicine as a whole - and chose to confront or rather employ deliverately legal struggles as a tactic. Such series of tough line was in part derived from endeavouring to pursue for independent establishment of specialised education, research and scientific knowledge base of its own and strict entry requirements in such a way as to preserve the originality of initial disease theory and health philosophy. It was a quite different route from the one taken by osteopaths that were on a similar occupational stage and faced the same socio-political situation (Saks 2000:232).

With the expansion of chiropractic, the American medical profession - represented primarily by the AMA - filed lawsuits against chiropractors on the ground of unlicenced practice of medicine and moved further to influence the state to impose aspiringchiropractors to pass basic science examinations controlled by biomedicine-controlled boards,

as it did to prospective osteopaths. Ironically, Such socio-political containment action is seen to be consequently conducive to enhancing relatively inferior standards with regard to specialised education and strengthening chiropractic in relation to 'ideology of an oppressed minority(Wardwell 1979:242)' and institutional and legal legitimacy - facilitatingunique identity coupled with strong antipathy against the medical profession (Weitz 2004: 381-382).

Under heavy lobbying form the AMA, it voted to refuse Medicare reimbursement to chiropractors in 1965. Outraged chiropractic patients responded with a massive public letter-writing campaign, which led the Congress in 1972 to pass legislation extending Medicare coverage to chiropractic services, despite the lack of perceived scientific research available at the time on its effects. This set the stage for state legislatures to require other insurance plans to reimburse for chiropractic care, at least in certain situations; by 1985, forty-two states had done so (Wardwell, 1988:179). Yet organized medicine continued to limit the ability of chiropractors to practice freely. In addition to fighting legislation designed to allow chiropractors to receive private insurance reimbursement, the AMA banned contact between chiropractors and its members, making it impossible for chiropractors anal medical practitioners to refer to each other. In response, chiropractors and their supporters filed antitrust suits in the late 1970s against the AMA and the AOA, alleging that these organizations had refrained trade illegally. Chiropractors eventually won or favourably settled out of court all the suits. As a result, overt opposition to chiropractic ended (Weitz 2004:381-382).

These changes have allowed chiropractors to solidify their social position. Use of chiropractic is widespread and more increasing across the country. That success, however, is bounded to chiropractors' status as 'limited' practitioners. Though insurers now often pay for chiropractic services but usually will do so only for treating specific conditions in specific ways (Eisenberg et al., 1988; 1574; Shekelle, 1998). State licensure laws sometimes set similar limits despite chiropractic' s desires to treat a broader range of problems. Most patients go to chiropractors for treatement of acute lower back pain, and only one percent for anything other than musculoskeletal problems (Hurwitz et al., 1988). Nevertheless, chiropractorscontinue to push for a wider role in health care. Many chiropractors believe that spinal problems underlie all illness and thus spinal manipulation can cure most health problems, from asthma to cancer (Consumer Reports, 1994). They believe they can serve effectively as primary care providers and now advertise heavily that they offer care for the whole family throughout the life course (Weitz 2004:381-382).

> Unlike osteopaths, chiropractors have fully retained their unique identity. The history of chiropractic illustrates how marginal practitioners, who treat a wide range of physical ailments and illnesses but have low social status, can become limited practitioners -confining their work to a limited range of treatment and bodily parts and thereby gaining greater social acceptance (Weitz 2004:380).

In Britain as well, osteopaths and chiropractics are the most advanced occupational groups among non-dominant practitioners in the country with regards to non-subjugated professionalisationas far as state regulation is concerned. Osteopaths acquired legal registration by the Osteopaths Act in 1993 and also chiropractors by the Chiropractic Act in 1994 respectively, after agreeing to conform to professional requirements set up by the state - the formalised form of practice, educational standards in terms of length and content, unified representative bodies of professional association and vocational ethics. While these professional groups obtained only official protection of exclusive usage ofthe title - 'osteopath' or 'chiropractor, ' they have not yet won exclusive monopoly of their practice unlike medical practitioners and so non-registered practitioners can keep doing their own practice of the same kind if they do not use the title of 'osteopath' or 'chiropractor' . This outcome starkly contrasts against that in the other side of the Atlantic Ocean.

History of osteopath in the UK set out with a few graduates from the founder' s school located at Kirksvillein the US. In 1911 they founded the British Osteopathic Association and in 1926 osteopaths that were not from Kirksville established the Incorporated Association. These two occupational bodies, for all positional differences, geared up jointly for statutory recognition -which is viewed as a

rare case in the politics of heterodox medicine where internal competition and resultant fragmentedness is by and large prevalent due to the lack of dominance and unification. What should be noted here is that most of other health occupations that have presently allied to medicine acknowledged subordination and medical supervision in exchange for fuller recognition and further moved on to join the British Medical Association' s Board of Registration of Medical Auxiliaries. However, osteopaths considered themselves as alternative practitioner independent of, and equal to medical doctor in the full sense of both treatment and diagnosis, as was the case in osteopaths in the United States. Osteopaths in Britain kept more faithful to the original principles and tookthe more fundamentalist approach in treatment than in the United States (Baer 1987:68). Such attitude was felt to a serious threat to medical ascendance and necessarily had to be faced by strong attacks from a medico-ministry alliance, which was manifested in concerted opposition to the attempted Osteopaths' Registration Bill in 1931(Larkin 1992:114, 117-118). Allied osteopathic groups sought independent state registration within self-regulatory powers in the 1930s by the bill. The state-medicine complex effectively managed to thwart the bills that were put forward by the osteopaths and some of members of parliament (Baer 1987:69; Saks 2003:75). Osteopaths' defiance against medical patronage led to exclusion from the progressively consequential National Health Service, and to further resultant marginalty in the first half of the 20th century (Larkin 1992:123). The marginalized lifecourse that osteopaths experienced in Britainhighlights the fate of group that did not seek to advance its position under the hierarchical patronage of dominant medicine and denied to trade off subordination to medicine for state recognition (Larkin 1992; Griggs 1997 in Saks 2003:75). Journey of chiropractic in the country has not been too far from that of osteopath. Recently, following osteopaths and chiropractics, non-medical acupuncturists and homeopaths in the UK have also striving to professionalise themselves by meeting required conditions for officially recognised status. They endeavoured to integrate spilt relevant associations, enhance educational quality and promote professional ethics, yet nonetheless still failed to obtain legal protection that the former two have obtained (Saks 2000:230-232).

## Ⅲ. Conclusion

As explored in the above, some non-dominant medicines adopted, as a way with which to acquire and protect the exclusive monopoly of its knowledge and practical skills, various forms of professionalism project, as dominant biomedical groups pressed up non-dominant medicines by virtue of marginalizing tactics. Meanwhile, non-dominant medicines took somewhat distinctive professionalisation strategies from each other. Strategies they took were diversified depending on medical philosophy, healing modality, the degree of occupational solidarity embodied as forms of medical organisation, and especially vocational aspiration and prospect. Change of socio-medical culture and the state' s policy seems to have wielded critical influence on the determination of the ups and downs of non-dominant medicines. From the long-term time span, dominant biomedicine did not have much influence of the ups and downs of marginalized medicines in so far as in the case of osteopathy and chiropractic in England and the U. S.

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