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UNIVERSITY OF SOUTHAMPTON

FACULTY OF SOCIAL & HUMAN SCIENCES

School of Social Sciences

**The Origins and Professional Development
of Chiropractic in Britain**

By

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Thesis for the degree of Doctor of Philosophy

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ABSTRACT

FACULTY OF SOCIAL & HUMAN SCIENCES
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THE ORIGINS AND PROFESSIONAL DEVELOPMENT OF CHIROPRACTIC IN BRITAIN

By Francis James Howitt Wilson

In June 2001 the title 'chiropractor' came to be protected under British law and those who called themselves chiropractors attained a position of increased legitimacy within British society. Yet the details of chiropractic's journey to statutory recognition have not been thoroughly explored in contemporary literature. The origins and development of chiropractic in Britain have received meagre attention from historical scholars. This thesis uses a neo-Weberian approach to explore the history of chiropractic in Britain through the lens of 'professionalisation'. It investigates the emergence of chiropractic in Britain, and details how and why chiropractic developed in the way that it did, assessing the significance of processes and events in respect to chiropractic's professionalisation, and examining intra- and inter-occupational tensions.

The thesis is primarily a product of documentary research, but is also informed by interviews undertaken to provide oral testimonies. Although the origins of chiropractic are usually traced back to the 1890s, to Davenport, Iowa, and to the practice of Daniel David Palmer, it is argued in this thesis that it is misleading to claim that chiropractic was 'discovered' by Daniel Palmer, or that chiropractic in Britain was entirely an 'import' from the United States. Instead, chiropractic's origins were complex and multifarious and form part of a broader history of manipulative practices. With regard to the development of chiropractic in Britain, chiropractic's history is intertwined with that of osteopathy, and has involved medicalisation. This study demonstrates that through the course of its evolution chiropractic was subject to processes that can usefully be described in terms of professionalisation, sharing features in common with the professionalisation of other occupational groups described in historical and sociological literature. Even so, chiropractors did not attain the social presence or cultural authority of archetypal professionals such as medical doctors or lawyers. Although protection of title was achieved, many problems have remained, including divisions within the occupation.

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AUTHOR'S DECLARATION

I, FRANCIS JAMES HOWITT WILSON, declare that the thesis entitled 'The Origins and Professional Development of Chiropractic in Britain' and the work presented in the thesis are both my own, and have been generated by me as the result of my own original research. I confirm that:

- This work was done wholly or mainly while in candidature for a research degree at this University;
- Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
- Where I have consulted the published work of others, this is always clearly attributed;
- Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
- I have acknowledged all main sources of help;
- Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
- This work has not been published before submission, but I have produced a number of articles relating to the history of chiropractic in Britain and other parts of Europe during the course of my candidature. A list of these is included under my name in the reference list at the back of this thesis.

Signed

Date

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Above all, I would like to thank my wife Rachel for her unwavering commitment and faith in me.

Francis Wilson, October 2011

LIST OF ABBREVIATIONS USED IN THE TEXT

AECC	Anglo-European College of Chiropractic ¹
AHC	Association for the History of Chiropractic
AMED	Allied and Complementary Medicine Database
BAAC	British Association of Applied Chiropractic
BAMM	British Association of Manipulative Medicine
BCA	British Chiropractic Association ²
BHFS	British Health Freedom Society
BMA	British Medical Association
BOA	British Osteopathic Association
BPCA	British Pro-Chiropractic Association
BSO	British School of Osteopathy
CAM	Complementary and Alternative Medicine
CMCC	Canadian Memorial College of Chiropractic
CNAA	Council for National Academic Awards
CPSM	Council for Professions Supplementary to Medicine
DC	Doctor of Chiropractic
DHSS	Department of Health and Social Security
ECCE	European Council on Chiropractic Education
ECU	European Chiropractors' Union ³
GCC	General Chiropractic Council
GCNT	General Council of Natural Therapeutics
GCRO	General Council and Register of Osteopaths
GMC	General Medical Council
GOC	General Optical Council
GOsC	General Osteopathic Council

GP	General Practitioner
ICL	Index to Chiropractic Literature
IPC	Institute of Pure Chiropractic
JCUPA	Joint Committee of Unorthodox Practitioner Associations
MANTIS	Manual, Alternative and Natural Therapy Index System
MCA	McTimoney Chiropractic Association
MeSH	Medical Subject Headings
MORI	Market and Opinion Research International
MRC	Medical Research Council
NHS	National Health Service
NSAID	Non-Steroidal Anti-Inflammatory Drug
OAGB	Osteopathic Association of Great Britain
RCT	Randomised Controlled Clinical Trial
SCA	Scottish Chiropractic Association
UCA	United Chiropractic Association ⁴
UCA	Universal Chiropractors' Association ⁴
WFC	World Federation of Chiropractic

Historical notes:

1. The Anglo-European College of Chiropractic was originally named the Anglo-European College of Chiropractic.
2. The British Chiropractic Association was originally named the British Chiropractors' Association.
3. The European Chiropractors' Union was originally named the European Chiropractic Union.
4. The Universal Chiropractors' Association was formed in the United States in 1906. In 1930 it amalgamated with the American Chiropractic Association to become the National Chiropractic Association. The United Chiropractic Association was founded in Britain in 2000. It exists to this day.

Not when truth is dirty, but when it is shallow, does the enlightened man dislike to wade into its waters.

Friedrich Nietzsche

Nietzsche F. (2003). *Thus Spoke Zarathustra* (Translated from German by R.J. Hollingdale), p. 82. Penguin Books, London.

CHAPTER 1

Introduction

The aim of this thesis is to explore and critically evaluate the history of chiropractic in Britain from its origins to the point of protection of title under British law in 2001. The lens of ‘professionalisation’ is used to assist in the understanding of how and why changes occurred that resulted in chiropractic moving from a very marginal status within British society in the early years of the twentieth century, to become an occupation with legal protection of title and formalised educational standards as a route of entry for practitioners. In view of the fact that professionalisation is a concept that has been unpacked by sociologists, it is to be a sociologically informed history.

It was anticipated that professionalisation would provide a practical conceptual framework for the examination of chiropractic’s history, a framework that had been applied by academics to other occupational groups, and a framework that had a wealth of theoretical and empirical literature relating to it. A preliminary assessment suggested that chiropractic had been through a process of development that might usefully be described in terms of professionalisation. If employed pragmatically, it was considered that professionalisation could provide a sufficiently flexible framework for the study, although in interpreting data it was recognised that it would be important not to inappropriately force findings into the framework of professionalisation, thus potentially distorting truth.

This introductory chapter begins with a preliminary assessment of the position attained by chiropractic in 2001. It is followed by a review of relevant historical scholarship, offering information about previous related studies, and highlighting the gap in knowledge to be considered. Sections 1.3 and 1.4 focus on the sociology of professions, developing the conceptual framework that will be used to inform the main body of the text. The chapter concludes by defining the precise objectives of the study.

1.1 Chiropractic in Britain: a snapshot of its position in 2001

There is probably no single definition of chiropractic on which all chiropractors, let alone all observers, would agree. Nonetheless, it is appropriate to provide a working definition of chiropractic at the outset. The following is the definition approved by the Assembly of the

World Federation of Chiropractic (WFC) in 1999 (World Federation of Chiropractic, 1999).

The self-description of chiropractic as a ‘profession’ is noteworthy:

Chiropractic is a healthcare profession concerned with the diagnosis, treatment and prevention of mechanical disorders of the musculoskeletal system and the effects of these disorders on the function of the nervous system and general health. There is an emphasis on manual treatments including spinal manipulation or adjustment.

In relation to the above definition it should be recognised that the word ‘manipulation’ encompasses different meanings (see Wardwell, 1992, p. 19). It has been used to refer to procedures employed by medical doctors and others to reduce (restore the normal position of) fractures and dislocations. In relation to their practice, chiropractors have generally employed the term to describe manual therapeutic thrust procedures applied to joints with the aim of correcting what have been perceived to be small abnormalities in joint position (subluxation), and / or aberrant joint function, and / or to influence nervous transmission.

It was estimated that globally in 2001 there were in the region of 90,000 individuals who called themselves chiropractors (Chiropractic Report, 2001). The vast majority, some 70,000, practised in the United States. Fewer than 2,000 practised in the United Kingdom. Given that the population of the United Kingdom at the time of the 2001 Census was a little under 59 million, it can be deduced that there were fewer than four chiropractors to every 100,000 individuals living in the UK. In comparison, figures from the 2001 Census in England and Wales suggest that there were about 230 medical doctors per 100,000 population; 40 dental practitioners per 100,000 population; and 790 nurses, midwives and health visitors per 100,000 population (Wheeler *et al.*, 2005). In the British context therefore, chiropractic was a relatively small healthcare occupation.

The typical chiropractor practising in Britain at the turn of the twenty-first century worked exclusively within the private sector (Wilson, 2003a). The majority of chiropractors practised in the south of England, providing services for those who could afford to consult them, rather than in direct proportion to clinical priority or need. Very few patients were able to gain access to chiropractic services paid for by the National Health Service. There is evidence that implies that a large proportion of the British public did not know what chiropractors did. A MORI poll of 2,037 adults, conducted in 2004, and intended to be nationally representative, suggested that 56% of British adults knew, in broad terms, what chiropractors did, and that one in five had a more detailed knowledge about the sorts of conditions that chiropractors managed (General Chiropractic Council, 2004a). Awareness

was highest amongst those with “professional” or “managerial” occupations, those aged between 35 and 44, and those with higher educational qualifications. Geographically, those living in the south-west and south-east of England, and those living in Scotland, were most likely to know, without prompting, what chiropractors did. The results of another survey, conducted in 2001 by Thomas and Coleman, suggested that 1.6% of the adult population of the UK had visited a chiropractor within the previous twelve months (Thomas & Coleman, 2004).

In 2001 chiropractors practising in Britain may have lacked the social status of iconic ‘professionals’ such as medical doctors and lawyers, but in spite of their small numbers, limited understanding of their work by the public, and their meagre presence within the NHS, they had gained official government recognition in the form of the *Chiropractors Act*. Within the Act, chiropractic was described as a ‘profession’ (Act of Parliament, 1994, sect. 1). From a legal perspective, therefore, chiropractic might reasonably be considered a profession, however, from a sociological perspective, as upcoming discussions will illustrate, the situation is more complex.

The *Chiropractors Act* paved the way for the establishment of a General Chiropractic Council (GCC). In June 2001 it became a legal offence in the UK for any person to call himself or herself a chiropractor, or claim to practise chiropractic, unless registered with the GCC. All those practising chiropractic in Britain became subject to statutory regulation. Courses in chiropractic at four British schools were recognised by the GCC, those of the Anglo-European College of Chiropractic (AECC), the McTimoney College of Chiropractic, the University of Glamorgan, and the University of Surrey.

Questions as to how and why chiropractic came to be the subject of legal protection are not only fundamental to this thesis, but form its starting point. By the time of the Act, chiropractors in Britain were a well organised collective, with established associations and educational institutions, and with an air of apparent unity. In the build up to the Act, the image projected by leaders within chiropractic, and presented to strategic elites, was of practitioners who employed a scientific approach to clinical practice, practitioners who understood and were prepared to play by the rules of medical orthodoxy, and who adhered to defined ethical standards of practice. Chiropractors were portrayed as limited scope practitioners, who focused primarily on the diagnosis and management of musculoskeletal conditions, such as back pain, clinicians who wished to protect the public and their discipline from those deemed to be insufficiently qualified who might masquerade as their colleagues.

Behind the projected image however, was a more complex reality. Chiropractors were a heterogeneous group. Traditional chiropractic principles conflicted with the image presented in the cause of statutory regulation. The vision of the man widely credited with being the founder of chiropractic, Daniel David Palmer, was not of a discipline ‘complementary’ to the orthodox medicine of his day, but of one ‘alternative’ and exclusive to it. Palmer had practised in the United States in the late nineteenth and early twentieth centuries, but his thinking remained influential across the chiropractic world at the end of the twentieth and at the beginning of the twenty-first. Not every chiropractor in Britain was in favour of what might be described as ‘medicalised chiropractic’. Within British chiropractic there was diversity of opinion and practice, with distinct differences in perspectives and approaches between members of different chiropractic associations (Wilson, 2003a). Some chiropractors considered themselves diagnosticians, others did not. Educational variations were a source of intra-occupational tension and fierce debate.

At the inter-occupational level, chiropractors had failed to negotiate a ‘jurisdiction’ (sphere of activity) within the healthcare marketplace that was theirs and theirs alone. Instead, the field of conservative (non-surgical) neuromusculoskeletal healthcare in which they functioned was shared with others, notably with medical doctors, physiotherapists and osteopaths. In June 2001 the title chiropractor became protected under law, but no scope of clinical activity or territory was protected solely for chiropractors. The distinction between chiropractor and osteopath, in terms of clinical approach, was not clear-cut, and remained a potential source of confusion for those seeking to consult one or other.

One way of viewing professionalisation is in terms of a regulatory strategy (Moran, 2002, p. 19), with the attainment of statutory regulation marking a critical point. On this basis it can be argued that legal protection of title under British law in 2001 marked a key moment in chiropractic’s professionalisation. Even so, the absence of the unequivocal mainstreaming of clinical chiropractic, epitomised by chiropractic’s lack of integration into the NHS, may lead the observer to question the extent to which chiropractic had truly achieved professional status.

1.2 Historical scholarship in chiropractic

The emphasis in the study of the history of chiropractic to date has been on chiropractic in North America. The first doctoral thesis on the subject was completed by Wardwell in 1951, with a number of others following in more recent years (for example: Biggs, 1989; Smith-Cunnien, 1990; Moore, 1990; Gaucher-Peslherbe, 1994; Harris, 2000). The establishment of

an Association for the History of Chiropractic (AHC) in 1980, and the introduction of a dedicated journal, *Chiropractic History*, a year later, did much to increase the availability of secondary literature in the field. Papers have been published by both amateur and academic historians, and by both chiropractic and non-chiropractic investigators (Keating, 1992 & 2001). A variety of books have been produced (for example: Gielow, 1981; Wardwell, 1992; Moore, 1993; Peterson & Wiese, 1995; Keating, 1997; Keating, Callender & Cleveland, 1998; Keating, Cleveland & Menke, 2004). Amongst the written histories of chiropractic in North America are several that have explored sociological themes. In Canada Biggs and Coburn have published articles examining issues of chiropractic's legitimisation and professionalisation (For example: Biggs, 1985, 1991 & 1994; Coburn, 1991; Coburn & Biggs, 1986).

The history of chiropractic in Europe has not received so much attention as North America, but there have nevertheless been an assortment of papers published, and at least one doctoral thesis completed (Bak-Jensen, 2004). In the summer of 2007 an issue of *Chiropractic History* was dedicated to the history of chiropractic in Europe. A review of contemporary secondary histories that have appeared in periodicals published in English was presented in a piece entitled 'Chiropractic in Europe: a guide to historical articles' (Wilson & Dendy, 2007). The book *Chiropractic in Europe: An Illustrated History* (Wilson, 2007), which was commissioned by the European Chiropractors' Union, offers an overview of the history of chiropractic from a European perspective, and includes a series of articles about chiropractic's development in individual European nations.

Bak-Jensen's doctoral study examined the place of chiropractic within Danish society in and around 1930. There has been no study of similar detail examining chiropractic in pre-World War II Britain, however a body of literature does exist that provides perspectives on various aspects of chiropractic's development in Britain. For example, in the 1980s and early 1990s Baer produced a series of papers in which he gave an overview of the socio-political development of chiropractic in Britain and that of the related occupation of osteopathy (Baer, 1984a, 1984b, 1985, 1987a & 1991). King completed an MA thesis entitled *The Professionalization of Complementary Systems of Medicine in Britain: The Case of Chiropractic* (King T., 1995), and wrote an associated article 'Professions, power and therapeutic responsibility' (King, 1998). The evolution of McTimoney chiropractic as a branch of chiropractic in Britain was described by Harding in his book *McTimoney Chiropractic: The First Twenty-Five Years* (1997). In *A New Medical Pluralism? Alternative Medicine, Doctors, Patients, and the State*, Cant and Sharma (1999, pp. 144-147) presented a brief study on chiropractic in Britain in which they argued that in order to

legitimise themselves in preparation for statutory regulation, chiropractors de-emphasised controversial elements of their treatment, narrowed their scope of practice, and linked themselves to the scientific and established medical paradigm. Cant and Sharma's analysis will be tested and extended by this thesis.

As well as those who have focused in significant detail on chiropractic *per se*, there also exist a number of historical writings concerning the wider field of non-orthodox healthcare relevant to the understanding of chiropractic's history in Britain. Amongst the most pertinent to this thesis are works by Saks and Bivins. In *Orthodox and Alternative Medicine: Politics, Professionalization and Health Care* (2003a) Saks set out a sociological analysis of the history of non-orthodox healthcare occupations in Britain and the United States, including discussion on the emergence of what he described as a "counter-culture" to medical orthodoxy in both countries, a counter-culture that he argued peaked between the mid-1960s and mid-1970s (pp. 94-123). It would be a mistake to view chiropractic's professionalisation in isolation from this context, of which it might be seen to be an intrinsic part. The relevance of Bivins' work, which has focused attention on the transference of healthcare expertise between different cultures, includes the distinction that she draws between 'alternative' and 'complementary' healthcare occupations. It is a distinction that is important, yet it is also one that has sometimes been neglected by those who have used the umbrella term 'complementary and alternative medicine' (CAM). The words 'alternative' and 'complementary' do not have the same meaning. In relation to healthcare they have very different implications. In *Alternative Medicine? A History* Bivins wrote (Bivins, 2007, p. 38):

Because biomedicine positions itself as possessing absolute authority – knowledge that is true for and of all bodies, everywhere, independent of culture – its proponents tend to resist claims to parity made by other medical systems. Practitioners who hold different medical beliefs, or who practise medicine, or produce medical knowledge in other ways must generally therefore choose between positioning themselves and their medical practices as either 'complementary' or 'alternative' to biomedicine. Each position entails accepting a certain relationship with medical orthodoxy. If practitioners choose to regard their practices as 'complementary' to biomedicine, then they are accepting a more or less subordinate place within the orthodox hierarchy. The 'complementary' label accepts the universalizing claims of biomedicine; this has obvious implications in turn for the truth status of the 'complementary' system (particularly if it rests on another culture's cosmology or body model). On the other hand, the label 'alternative' expresses an oppositional relationship between the system or practice to which it is applied, and biomedicine. Although this category resists incorporation and assimilation within biomedicine, and therefore escapes a lower status in the biomedical hierarchy of knowledge, it also hinders

acceptance into the institutions of medical orthodoxy – the loci of most medical care in contemporary society.

In spite of an increasing amount of available information relevant to the history of chiropractic, one thing that has been lacking to date has been an in-depth investigation and analysis of chiropractic's history in Britain from its origins to contemporary times grounded in a thorough examination of primary sources. Martin (1995a) asserted that primary sources in chiropractic history can be difficult to locate, yet it is only through detailed consideration of such sources that the fullest picture of chiropractic's history can take shape. An aspiration in planning for this doctoral study was to engage in a more detailed survey of the history of chiropractic in Britain than previously undertaken by others.

Whereas the quantity of historical writing about chiropractic has become appreciable, a fact that tells us something of chiropractic's status today, its quality has on occasions been called into question (for example: Martin, 1995a & 1995b). As in many other fields of history, there have been inaccuracies that have circulated about chiropractic's past, incorrect assertions that have become part of its popular recorded history. For example, that Daniel David Palmer was born in Port Perry, Ontario, where a monument was erected to his memory, when in fact he was born near Toronto (Keating, 2005a). Of greater importance, however, is the fact that a number of contemporary chiropractic histories have tended to promote chiropractic, or particular sub-groups within it, at the expense of other perspectives. Chiropractors writing about their history are not disinterested parties. Some commemorative histories, including my own (Wilson, 2005a & 2007), have provided visions of this nature. They have been written with particular audiences in mind. In terms of professionalisation, such histories may be seen to enhance group solidarity, and they may function to promote positive visions of social identity, both of which are useful functions, but a more balanced and critical approach is generally expected of academic historical research (MacMillan, 2009, pp. 51-78).

Although it is true that chiropractors writing about the history of their occupation sometimes have had little formal training in historical methods, and they have had a vested interest in painting a positive picture of their occupation's past, it is also possible that inter-occupational rivalries have played a part in the publication of certain critical comments about chiropractic written histories. An article in *Chiropractic History* published in 1995, written in response to a book review which appeared in the *Bulletin of the History of Medicine*, went so far as to ask whether there was a negative "medical historical attitude" towards chiropractic (Chiropractic History, 1995). The claim, whether true or not, is relevant

to the theme of professionalisation as power struggles between occupations are seen as being inherent to the process and chiropractic's history has involved competition with the medical profession.

For their part, chiropractors have not always welcomed historical accounts about their occupation by non-chiropractic historians. In 1951, Bartlett Joshua Palmer, Daniel David Palmer's son, wrote of Wardwell's doctoral thesis (Wardwell, 1992, pp. 74-75):

What is the hidden purpose of this laborious production?

Are you a D.C. [Doctor of Chiropractic]; if so, from what school? Evidently you are a law or medic student of Harvard...

You have quoted more anti-Chiropractic sources than pro-Chiropractic...

Your comments are in the main biased against us...

I come to the conclusion that you have labored long and hard to "sell Chiropractic down the river".

In so far as reasonably achievable, the intention in preparing this thesis has been to produce a history that takes into account different perspectives, one in which arguments and conclusions stem from balanced and thorough analysis of historical sources, rather than pre-conceived ideas or ideals. It has been necessary to question the received story of chiropractic's development.

1.3 The sociology of professions

'Professions' have received significant attention in historical and sociological writings of the twentieth and early twenty-first centuries, particularly in Anglo-American context. In historical perspective, the medical profession and the legal profession have often been considered 'ideal' professions and other occupational groups compared to them. It is sociologists who have undertaken much of the theoretical work in the field, and it is to that body of literature that attention is now turned. This section provides a review of relevant sociological literature on professions and professionalisation. The following section will focus on the application of this literature to the study of chiropractic's history in Britain.

Carr-Saunders and Wilson's *The Professions* (1933) was perhaps the first publication in which an attempt at a detailed systematic analysis of professions was described. It epitomised a structural-functional approach that became dominant in much early study of the subject, an approach that tended to paint professions in a positive light, as the 'honoured

servants of public need" (Freidson, 1983, p. 19). Academic interest focused on questions such as: 'Is this, or that occupation a profession?' and "What part do the professions play in the established order of society?" (Macdonald, 1995, p. xii). Carr-Saunders and Wilson, and others that followed them, attempted to identify the essence of professions by describing the characteristics, or 'traits', that they considered distinguished professions from other occupational groups. Greenwood (1966), for example, whilst acknowledging that the distinction between professions and other occupations was not clear-cut, suggested that professions, considered in their ideal form, could be identified by the following attributes: (1) A systematic body of theory, or system of abstract propositions, that described in general terms the classes of phenomena comprising the profession's focus of interest; (2) Authority recognised by the clientele; (3) Evidence of broader community sanction and approval of that authority, in the form of a series of powers and privileges conferred upon the profession by the community; (4) An ethical code that regulated relations with clients and colleagues; (5) A professional culture, sustained by professional associations.

Assuming that the characteristics of the ideal profession could be established, the trait approach appeared to lend itself to a categorisation of occupational groups as professional, or non-professional, depending on the traits they possessed. Unfortunately, universal agreement on a single set of traits to define professions was elusive and there was ambiguity in practical application of the trait approach to individual occupations (Klegon, 1978; Abbott, 1988, p. 4). Few occupations met the 'ideal' standards of medicine and law.

One response to perceived limitations in the trait approach was to move from an examination of profession as an end state, to consider the process of professionalisation. If the characteristics of an occupation that had achieved professional status could not be universally agreed upon, were there consistent steps in professionalisation that might be identified? Wilensky (1964) argued that whilst there was a general tendency for occupations to seek professional status, few actually attained it. There did, however, appear to be just such a regular sequence, or series of steps, through which movement towards professional status occurred. Whilst recognising that there were some variations in sequence between different occupations, an examination of eighteen American occupations suggested to Wilensky that the typical sequence of development was as follows: (1) A full-time commitment to a task that needed doing; (2) Establishment of a training school, which if not originally set up within the university system would eventually seek contact with it; (3) Formation of a professional association; (4) Protection of job territory under law, following political agitation; (5) Establishment of a formal code of ethics.

Vollmer and Mills were amongst other authors who examined professionalisation during the 1960s. In their discussions they avoided using the term ‘profession’ except to describe an ideal type of occupational organisation that does not exist in reality. They suggested that (Vollmer & Mills, 1966, pp. vii-viii):

...the concept of the “profession” be applied only to an abstract model of occupational organization, and that the concept of “professionalization” be used to refer to the dynamic *process* [original emphasis] whereby many occupations can be observed to change in certain crucial characteristics in the direction of a “profession”, even though some of these may not move far in that direction. It follows that these crucial characteristics constitute specifiable criteria of professionalization.

Unfortunately, whether the focus was on the structure / function of professions, or on the processes of professionalisation, the matter of definition remained a topic of discourse and contention. Uncertainty remained. The sequence of professionalisation and its necessary steps were not universally agreed upon. One response to the problem of definition involved an attempt to sidestep it. Whilst accepting that ‘profession’ was an expression that was widely used, and an expression that had meaning to those who employed it, it was argued that it was simply not possible to objectively establish the credentials of professional occupations. Instead, professions were to be considered a natural ‘folk category’, best understood as being those occupations that interested parties within societies described as being professions at any given time (Dingwall, 1976; Veysey, 1988, pp. 17-18). The purpose of academic activity was therefore to consider such issues as the clarification of historical and contemporary uses of the term profession, rather than a fruitless search for definition. In spite of this, debates over definition continued. For many the issue was too important to be evaded. It warranted consideration even in its complexity. Concerning the process of professionalisation, Freidson (1983, pp. 21-22) would later point out that:

To speak about the process of professionalisation requires one to define the direction of the process, and the end-state of professionalism toward which an occupation may be moving. Without *some* [original emphasis] definition of profession the concept of professionalisation is virtually meaningless, as is the intention to study process rather than structure. One cannot study process without a definition guiding one’s focus any more fruitfully than one can study structure without a definition.

From the 1960s onwards there was a general movement away from structural-functionalism within sociology, diversification, and an increased interest in what might broadly be described as power and action-based approaches. In examining professions within an Anglo-

American context, sociologists tended to de-emphasise taxonomy and the positive functions and achievements of the professions. Instead, the focus moved to a critical perspective from which professions were seen as dominant and powerful occupational groups. Action-based approaches within the sociology of professions have been epitomised by the question: “How do such occupations manage to persuade society to grant them their privileged position?” (Macdonald, 1995, p. xii).

Following an examination of the medical profession, Freidson (1970, pp. 71-72) suggested that the only truly important and uniform criterion for distinguishing professions from other occupations was ‘autonomy’. Professions were those occupations that had, through a process of negotiation, established the support of social and political elites and persuaded society to grant them control over an area of work. Dominance and autonomy, rather than the traditional values of collegiality and trust, were the keys to understanding professional status.

Larson (1977) developed themes present in Freidson’s early work on the professions. For her, professionalisation could be understood in terms of a ‘project’ undertaken by occupations in order to achieve a special status within society and market control within an area of work. Professions offered society specialised knowledge and skills and in return society granted prestige and the ability to wield power (Larson, 1977, p. xvii):

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.

Larson (1977, p. 67) distinguished between the means through which occupations attracted prestige. On the one hand occupations could attract prestige via means defined by the group itself, such as systematic training and testing. Larson termed these “autonomous” means. On the other hand, occupations could become prestigious through various forms of external sanction, for example through state licensing. Larson termed these “heteronomous” means.

The work of Freidson and Larson, and of other writers of the period, such as Berlant (1975), who like Larson stressed the importance of monopoly in understanding professions, set the scene for what was to come. In the 1980s Abbott (1988) highlighted the interdependence of occupational groups. He argued that a focus on such areas as the formation of associations, licensing and codes of ethics, seen in previous accounts of professionalisation, ran the risk of

missing a fundamental fact of professional life, that of inter-professional competition. He argued that occupations formed an interdependent system that could not be effectively understood by focusing on either the development of individual occupations in isolation, or on parallels in occupational development. Instead, as Freidson had suggested, control was the key to professional success. For Abbott it was control specifically of knowledge and its application that was important, and this was achieved through a process of attacking and dominating outsiders who threatened the jurisdiction of the profession concerned.

Jurisdictional boundaries were perpetually in dispute, both at local and national level. Some occupations achieved relatively complete control over jurisdiction. Others did not. Some found themselves subordinate to another occupational group.

In considering the relationship between knowledge and power a number of sociologists drew upon the work of Michel Foucault. Foucault had argued that knowledge was linked to power, and that those who exercised power, such as professional groups, often had the authority to define the boundaries of knowledge within their fields, determining the nature of what was considered 'truthful' within their spheres of activity. Foucault (1977, p. 28) wrote that:

It is not the activity of the subject of knowledge that produces a corpus of knowledge, useful or resistant to power, but power-knowledge, the processes and struggles that transverse it and of which it is made up, that determines the forms and possible domains of knowledge.

In light of this, professional status was not to be considered inherently benign, but instead it was to be viewed as more morally ambiguous. Professions were successful occupational groups whose potential for influence extended to defining the nature of truth.

Whereas there was a tendency to view professionalisation as a process of upward social mobility, neo-Marxist sociology added to the debate on professions and professionalisation the concept of 'proletarianisation' (Oppenheimer, 1973; McKinlay & Arches, 1985; McKinlay & Stoeckle, 1988). Marxism implied that the processes of professionalisation were not necessarily unidirectional and that a lowering of the social status on the part of specific occupations, or their proletarianisation, was a distinct possibility, even an inevitability.

Notwithstanding the examination of professions from Marxist and Foucauldian perspectives, ideas that have their roots in the writings of Max Weber have been particularly influential within the sociological study of professions in recent decades. 'Neo-Weberianism', derived

from the work of Weber, and influenced by the work of Larson, became the dominant paradigm within the sociology of professions (Saks, 2003b). Although in the twenty-first century there has been a fresh sociological focus on analysis of the concept of ‘professionalism’ (for example see: Evetts, 2003), Saks (2010) has argued that Neo-Weberianism remains “the most incisive and empirically fruitful approach to professions in analysing such occupations in advanced societies”. Neo-Weberians have focused on the concept of ‘social closure’, and examined the processes by which professions have sought to regulate market conditions in their favour by restricting the access of other occupations to contested domains. An important moment in professionalisation is thus the point at which the state grants statutory regulation to an occupation, restricting access to knowledge and to the market in favour of the specified occupation (Macdonald, 1985). Legal protection of title is fundamental to the achievement of social closure and therefore offers one means of characterising the profession.

Of healthcare occupations in Britain and America, it was the medical profession that was first subject to statutory regulation, and it was the medical profession that during the nineteenth and twentieth centuries most convincingly established a position of autonomy and dominance within the healthcare arena (Freidson, 1970; Starr, 1982; Allsop, 2002). It is probably not surprising therefore, that of all the healthcare occupations it has been the medical profession that has attracted the most interest from neo-Weberian sociologists and others wishing to study professions and professionalisation.

The medical profession’s dominance in Anglo-American healthcare provision came at the expense of other occupational groups within the field, who, as Turner (1995, pp. 138-139) identified, were subordinated, limited or excluded. According to Turner, nursing and midwifery became subordinate to medicine, such that they could not be considered truly autonomous occupations. Dentists, optometrists and pharmacists, on the other hand, developed limited scopes of practice in order to appease the orthodox medical lobby. Dentists and optometrists limited their practice to a particular part of the body. Pharmacists limited their practice to a specific therapeutic method. Amongst the practices that the medical profession attempted to exclude from legitimisation through statutory regulation, Turner identified psychological counselling as carried out by members of the clergy, and also chiropractic.

Although the medical profession has been the primary focus of attention for those studying professions and professionalisation within the healthcare arena, academic interest has also extended beyond it to include examination of a number of other occupational groups. Within

the context of the United Kingdom, there have been a number of authors who have been active in this field. Amongst them are Larkin (1979, 1980, 1981, 1983, 2002 & 2003), who examined dentistry and those occupations that fell under the 1960 *Professions Supplementary to Medicine Act*, Nettleton (1988 & 1989), who has also examined dentistry; Witz (1992 & 1994), who as well as considering issues of gender, has studied the occupations of nursing, midwifery and radiography; Borthwick (1997, 1999, 2000a, 2000b, 2001a & 2001b), who has studied podiatry; Mercer (1978 & 1980), who has studied physiotherapy; and Øvretveit (1985 & 1994), who, like Mercer, has studied physiotherapy. As previously described, Baer, King, Harding, Cant and Sharma examined aspects of the socio-political development and professionalisation of chiropractic in Britain.

In its application to healthcare, sociologists recognised that professionalisation was not necessarily a unidirectional process, and that de-professionalisation, or the loss of professional qualities, was also a distinct possibility. It must also be recognised that the processes of professionalisation are time dependent. Professions are the product of particular social orders, social orders that can be, and indeed have been, subject to change. In recent years alterations in relationships between professions and states, and the globalisation of politics and economics, have resulted in a new level of complexity in respect to professions, and a re-evaluation of professions and professionalisation has taken place (Dingwall, 1999; Evetts, 2006; Kuhlmann & Saks, 2008). As Evetts (2006) has pointed out, the vision of the profession having exclusive ownership of an area of expertise, autonomy, and discretion in work practices, has been challenged by a new vision of bureaucracy, accountability and political control. In chiropractic's case, recent regulatory reforms have resulted in a change from a situation where chiropractors elected some members of the General Chiropractic Council, to one where today all members of the GCC are appointed by the Privy Council (Statutory Instrument, 2008). Where the GCC initially functioned to promote chiropractic, today it no longer has that function (Dixon, 2008). In the twenty-first century the press have often been critical of professions. Articles published in the popular press have had the effect of calling into question chiropractic's cultural authority. Of particular note is an article which appeared in *The Guardian* newspaper in April 2008, in which it was claimed that the British Chiropractic Association promoted bogus treatments (Singh, 2008), an article to which the British Chiropractic Association responded by taking legal action.

Whereas developments such as these will be of potential interest to contemporary sociologists, and also of potential interest to tomorrow's historians, in the context of this thesis it is necessary to recognise 2001 as a temporal boundary. This thesis is concerned primarily with the history and professionalisation of chiropractic in Britain to the point of

protection of title. Nevertheless, in the concluding chapter of the thesis the legacy that this period of history has imparted to the present will be assessed, and its findings will be considered in current context.

1.4 Professionalisation as a lens for study of the history of chiropractic in Britain

Professionalisation offered the prospect of a practical means of examining the socio-political transformation of chiropractic to the point of protection of title, an approach that had been explored within sociological literature, and an approach that had been widely applied to other occupations. The neo-Weberian emphasis on social closure as a landmark in professionalisation made it a natural choice for the study of occupational development to the point of protection of title. Initial observations suggested that the concept of professionalisation could usefully be applied to chiropractic's British twentieth century history. Thought was given to lessons that might be learnt from the sociology of professions in order that the approach might be most fruitfully applied. Key lessons from the sociology of professions relevant to this work, including the strengths and weaknesses of possible approaches, are now discussed.

At the outset of the study it was recognised that the substantive focus on developments leading to protection of title would necessitate some omissions, and that the framework of professionalisation would necessitate a particular emphasis in selection of material. There would be aspects of the history of chiropractic that would be left out because of the framework to be used. This was considered a reasonable sacrifice in light of the anticipated benefits of the approach.

In respect to structural-functional approaches to professions and professionalisation, it is true that attempts to classify those occupations that are or are not professions on the basis of 'traits', or to identify the 'steps' that take place during the process of professionalisation, have been widely discredited in the forms in which they were originally proposed (Evetts, 2006). It is true that a key problem has been that universal agreement on the traits of professions, or the steps of professionalisation, has not been achieved. Nonetheless, it was considered appropriate to ask what might be gleaned from 'trait' and 'step' descriptors of professions that might add usefully to the understanding of chiropractic's professionalisation in Britain. It soon became clear that to discard these approaches in their entirety would be problematic. Either professionalisation leads to an end state or it does not. Without consideration of the end-state academic study of professionalisation becomes essentially meaningless, for professionalisation is seen to be going nowhere in particular. What

structural-functional approaches offer, and what has been considered of value to this examination of chiropractic's history, is a 'sense' of the kind of characteristics on which an occupation might base a plausible claim for professional status, and a 'sense' of the processes required to get there. What is to be avoided, and what it is hoped has been avoided, is an overly prescriptive approach.

In respect to action-based approaches to professionalisation, the publication of Larson's *The Rise of Professionalism: A Sociological Analysis* (1977) marked an important progression. The 'professional project' provides a constructive way of viewing chiropractic's development in Britain. That said, a potential weakness of Larson's approach to professionalisation is that arguably it assumes too conscious a pursuit of professionalisation strategies by occupations, inferring intention from outcome. It begs the question: 'To what extent do occupations wittingly engage in a quest for professional status?' Despite this, Larson's analysis has much to offer and her theoretical framework helps to 'sensitise' one to the ways in which developments, such as the formation of occupational associations and the achievement of statutory regulation, might be seen to enhance the prestige and economic status of occupations. In considering chiropractic, a distinction might be made between those elements of chiropractic's professionalisation that have come about primarily through the active involvement of chiropractors ('autonomous' means), and those that have come about primarily through external sanction ('heteronomous' means).

Abbott's *The System of Professions: An Essay on the Division of Expert Labor* (1988) draws the reader to focus on issues of inter-occupational competition and jurisdiction. Where it might be the case that Abbott overstates the relative significance of these issues at the expense of other elements in the history of professions, his work, like that of Larson, was considered to be of value to the examination of chiropractic's history in Britain. It was recognised that those who first called themselves chiropractors in Britain attempted to establish a place for themselves within the healthcare marketplace. In so doing, they came into competition with medical doctors, osteopaths and others. Thus, inter-occupational competition had to be considered an essential part of the chiropractic narrative. The establishment of jurisdiction in the face of competition is however but one part of the larger jigsaw that is professionalisation. This was something that was recognised by Macdonald in his review of the sociology of professions (Macdonald, 1995). Macdonald distinguished between what he considered to be the primary goals in professionalisation and the sub-goals of professionalisation (pp. 188-189). For him, the establishment of jurisdiction was a sub-goal. He described the primary objectives of the professional project as being high status in the social order and monopoly in the market for services based on specific expertise. He

described the sub-goals of the professional project as being: the establishment of jurisdiction; development of an appropriate system for selection, training and socialisation of practitioners; monopolisation of professional knowledge; and respectability.

In *The System of Professions* Abbott was critical of what he termed the ‘strong form hypothesis’ of professionalisation. According to Abbott (pp. 17-18), a series of assumptions have tended to underpin ‘synthetic’ (as opposed to empirically-based) visions of professionalisation. It has sometimes been assumed: (1) that change is unidirectional, that would-be professions evolve towards a given form, structurally and culturally; (2) that the evolution of individual professions does not explicitly depend upon that of others; (3) that the social structure and cultural claims of professions are more important than the work that professions do; (4) that professions are homogenous units; (5) that professionalisation is a process that does not change over time, thus lacking a history of its own.

In preparing for the current study it was recognised, as neo-Marxist philosophy highlights, that the process of professionalisation is not necessarily unidirectional. As Abbott argued, psychological mediums in North America, who at one stage might have been considered to be professionalising, ultimately disappeared into obscurity. Midwives in both Britain and the United States, confronted by the dominance of the medical profession in relation to contested domains, were held back in their attempts to professionalise and became largely subordinate to the medical profession. Professionalisation does not necessarily follow a regular order and its steps vary between occupations. One of the features of Wilensky’s (1964) view of professionalisation was that it was a process that tended to occur in a uniform fashion, even if, as he himself noted, there were exceptions to the general rule. Empirical evidence, however, suggests that in reality diversity can exist in the ways in which different occupations develop (Abbott, pp. 16-18). Once distinct groups, such as physicians, surgeons and apothecaries, have merged with one another. A preliminary assessment of chiropractic in Britain suggested that the order of its professionalisation in Britain differed from that proposed by Wilensky. In Britain, chiropractic associations came into existence before chiropractic schools, as there were pre-existing training facilities in North America.

Turning to the second of Abbott’s points, it must be recognised that individual occupations do not exist in a vacuum. The professionalisation of an occupation is not only dependent upon the activities of the occupation itself, but also upon the actions of others within society, and upon the social environment in which the occupation develops. Competition between occupations over realms of work is as much part of the story of professionalisation as the attainment of ‘professional’ social structures and cultural legitimacy. In this respect, it was

clear from the outset that the professionalisation of chiropractic in Britain differed significantly from that of medicine, by reason of the pre-existence of a dominant occupation within British healthcare that provided for a specific source of inter-occupational tension.

The nature of the work undertaken by an occupation is instrumental in defining its market and its relationships with other occupational groups within the marketplace. As regards chiropractic in Britain, as this thesis will show, issues of scope of practice and the bounds of chiropractic work are vital to the understanding of its professional development.

Within the thesis the concept of 'interest' is used to describe shared advantage or benefit to a particular group, such as chiropractors, or their patients. That is to say, the promotion of mutual good. Although occupational self-interest is often considered to be a part of professionalisation, so also is the expectation of service to the public, of support for the 'public interest', of altruism on the part of aspiring professionals (Saks, 1995, pp. 11-34). Consequently there is the potential for conflicts of interest to develop. Whilst some sociologists (especially early contributors to the sociology of professions) have favoured the idea of professional altruism, others, including Abbott, have been less trusting of the motives of professional groups, highlighting the importance of competing group interests, whether between aspirant professionals and those whom they serve, or between different occupational groups.

Related to the notion of 'public interest' is 'protection of the public'. In the context of healthcare, protection of the public entails safeguarding the populace against incompetent practitioners and deficient or defective clinical practices, thus ensuring that the potential for harm to patients is reduced. Regulation may provide a means to this end. Indeed from the government perspective protecting the public from unqualified or inadequately trained practitioners has been described as the principal purpose of healthcare regulation (House of Lords Select Committee on Science and Technology, 2000, p. 36).

Addressing Abbott's fourth point, in order to achieve the fullest understanding of the professionalisation of an occupation it is essential to consider inter-occupational dynamics, but it is also necessary to take account of intra-occupational divisions and conflicts. Occupations are not homogenous units. For the sake of simplicity in studying the processes of professionalisation, it is tempting to ignore internal differentiation, however, the history of internal differences and the struggles that have ensued between intra-occupational groups tends to be bound to the development of the occupation as a whole and for that reason it must not be ignored.

Finally, as the manner in which professionalisation occurs is related to social environment and also to the existence of other actors, so the processes of professionalisation may change over time. Chiropractic's professionalisation in Britain would almost certainly have been very different if chiropractic had existed in the first half of the nineteenth century and chiropractors had organised themselves in Britain prior to the *Medical Act* of 1858 (Act of Parliament, 1858), for subsequent to the Act there was a clearer legal partition between orthodox and unorthodox healthcare practitioners.

1.5 Objectives

In undertaking this study, the intention was to produce a sociologically informed history. The intention was not to use chiropractic as a case study to test or develop sociological theory, rather it was to take the idea of the profession and the concept of professionalisation as unpacked by sociologists, and use them in a practical way to facilitate study of the history of chiropractic in Britain. In light of the foregoing discussion, an action-based, in essence neo-Weberian approach to professionalisation, was considered the most appropriate framework for the study. There was a danger that the history of chiropractic might become distorted as a result of the particular lens being used. This was recognised and efforts were made to retain sufficient flexibility so as to enable a fair representation of developments. The key objectives of the study were as follows:

- To detail the history of chiropractic in Britain from its origins to the point of protection of title in 2001, using professionalisation as a lens.
- To assess the significance of processes and events in the professional development of chiropractic in Britain, taking account of how and why changes occurred.
- To critically evaluate intra- and extra-occupational factors in the professional development of chiropractic in Britain.
- To judge what was achieved through professionalisation and related processes, what was not achieved, and why, and consider the legacy bequeathed to the present.

CHAPTER 2

Methodology

A series of primary research questions followed from the key objectives that had been chosen to define the boundaries of the study. What were the origins of chiropractic in Britain? What were the main factors which enabled chiropractic in Britain to make the journey from being a highly marginal occupation on the fringe of healthcare to a situation where it could legitimately claim protection of title in 2001? How and why were particular processes and events relevant to the professional development of chiropractic in Britain? How and why were intra- and extra-occupational factors relevant to the professionalisation of chiropractic in Britain? What place had chiropractic achieved within British society at the beginning of the twenty-first century, what had been achieved through professionalisation and related processes, what had not been achieved, and why? What was the legacy bequeathed to the present by the processes of chiropractic's professional development up to and including 2001?

In order to answer these questions effectively a number of methodological issues had to be dealt with. This chapter begins with a focused discussion of methodological challenges relevant to the study. It then provides a factual account of the strategies used to collect and analyse data.

2.1 Methodological challenges

A goal of academic historians is to extricate the past from the present, to call into question social memories and nostalgic visions, in aspiration of an accurate approach to history (Tosh & Lang, 2006, pp. 1-27). In respect to this particular study, it was necessary to recognise that as a chiropractor, I, the researcher, came to the work with preconceptions, having been socialised into a way of thinking about chiropractic that was not dispassionate. Although it was my personal experiences as a chiropractor that led to my interest in this field of research, with such a background came potential for bias in the examination of chiropractic's history. On the other hand, my background provided for an understanding of the complexities and dynamics of chiropractic that few non-chiropractors could profess to have. Whereas it was important to attempt to examine chiropractic's history in a reasonably autonomous way, 'for its own sake', and 'as it actually was', it was also recognised that in

such a project the researcher could not help but become a part of the research, and that selection and interpretation of evidence would necessarily involve a degree of subjectivity. It was also recognised that the framework of professionalisation had potential to impart its own biases, notably a vision of progress along a broadly pre-determined path. What was considered essential was to attempt to produce a fair and balanced view of chiropractic's professionalisation, grounded in evaluation of a wide variety of sources, of particular significance being those that called into question personal preconceptions. It was also necessary to try to avoid improperly forcing data into the framework of professionalisation, and inappropriately selecting data so as to hold up a preconceived supposition of professionalisation.

In order to overcome personal biases one must first recognise them. In my case a potential source of influence was my background as a chiropractor, but also my particular affiliations within chiropractic and my opinions towards it (Table 1). During the study a deliberate attempt was made to seek out alternative perspectives and viewpoints, and to consider them in an empathetic way, on their own terms. For example, the opinions of non-chiropractors were sought through interview, including individuals who had some less than positive

Table 1: Potential sources of bias on the part of the researcher at the start of the study

Chiropractic affiliations
<ul style="list-style-type: none">• I came to the study a chiropractor, my research being part funded by the European Chiropractors' Union.• I graduated from, and was a member of faculty at, the Anglo-European College of Chiropractic.• I was a member of the British Chiropractic Association.
Opinions about chiropractic
<ul style="list-style-type: none">• I held a preference for a 'medicalised' view of chiropractic, in which chiropractic was seen as being 'complementary', rather than 'alternative' to medical orthodoxy.• I held a preference for chiropractors acting as evidence-based, limited scope healthcare practitioners, with a focus on the diagnosis and conservative management of musculoskeletal conditions, such as back pain.• I did not believe in chiropractic vitalism in the form proposed by Daniel David Palmer.

opinions about chiropractic, as were the opinions of chiropractors with different perspectives to my own. Every reasonable effort was made to make judgements on the basis of historical evidence. Judgements were subject to challenge from my supervisors and also others who peer-reviewed the work at various stages.

During the course of the study my initial biases were repeatedly challenged. Of course it was not the case that all of my historical opinions at the start of the study were unfounded, far from it, however during the study those of my opinions that did not stand up to rational appraisal of the emerging evidence were modified. In some cases, ideas that I came to the study with were replaced by new ones. In other cases, evidence supported my preconceptions and my opinions hardened. For example, on the one hand I found myself questioning the extent to which Daniel Palmer should be considered the 'discoverer' of chiropractic; on the other, I found that the balance of evidence tended to support my preconceptions about the inter-dependence of healthcare occupations.

Traditionally, it has been documents that have supplied the main source materials of historical research, however documents available in particular fields of history seldom provide complete records of the past. An initial problem for this project was identifying and gaining access to relevant documentary materials. In the autumn of 2001, when work first began on the project, there existed no library of British or European chiropractic history, and no concerted effort had been made in the United Kingdom to protect or catalogue chiropractic historical documents. Instead, source materials were widely dispersed, and it was not immediately clear how much data actually existed, or where to find these. It was recognised that much of the most easily obtainable data would probably originate from organised groups, and that the records, accounts and perspectives of those not so well organised, or those who had been historically less successful, might be more difficult to locate, or absent.

There was a concern that some documentary evidence that had once existed might have been destroyed. In discussions with him, Michael Copland-Griffiths (a chiropractor) recalled how he had saved a number of historical documents from a bonfire at the Anglo-European College of Chiropractic (Copland-Griffiths, 2003). One wonders what might have been lost over the years. There was also the concern that some information of potential interest might never have been written down. Was it possible that relevant views, opinions and reasons for action on the part of individuals or groups might not always have been recorded? It would be prudent to carry out a meticulous and widespread search for evidence, but also to recognise that there might be gaps in the documentary record. Further, whereas the focus of the project

was on chiropractic, the wider context of chiropractic's history and professionalisation could not be ignored if the most complete understanding of the history was to be achieved.

In evaluating evidence from individual written sources, issues of authenticity, credibility, representativeness and meaning had to be considered (Scott, 1990, pp. 6-8). It was appropriate to ask whether evidence was genuine, whether it was free from error and distortion, whether it was typical of its kind, and whether it was clear and unambiguous. Of course, it is sometimes the a-typicality of an account that makes it of interest to the historian, or the fact that evidence has been deliberately distorted that makes it noteworthy; nevertheless it is important to recognise such distinctions in the cause of historical accuracy. In the context of the current research, it was necessary to consider the possibility of material being produced by organisations for propaganda purposes, whether by chiropractors or by others. Was it really the case, for example, that chiropractors in Britain in 1930 were able to successfully treat acute appendicitis and rheumatic fever as was asserted (The Chiropractor, 1930a)? Did chiropractors genuinely believe that they could help these conditions, whether they were right or wrong in their judgment? Or were these exaggerations of the truth, or lies, written in support of chiropractic claims as to the cause of disease?

At an early stage it was decided that in order to facilitate a thorough study of chiropractic's professional development, and answer the research questions posed, evidence from oral interviews would be used to supplement documentary evidence. An initial series of interviews was also used to help in the formulation of research questions and the identification of sources.

Oral history is an attempt to understand the past through the spoken word. Interviews are used to capture memories, reconstruct historical events and explore experiences. Whereas documentary research is traditional in academic history, oral history is a relatively new phenomenon. Its rise in popularity owes much to diversification within historical inquiry in the twentieth century, and to the availability of portable recording media, such as tape recorders, minidiscs, solid-state and hard-disk recorders.

Proponents of oral history argue that it adds an important dimension to the study of the past (Thompson, 2000, pp. 1-24; Perks & Thomson, 2006, pp. ix-xiv). It allows for evidence from new directions, evidence that is personal and often challenging to traditional assumptions. It adds a depth that is not available in written sources, and opens up new areas of enquiry. Through oral history, it is argued, it is possible to capture the subjective experiences of individuals that would otherwise be hidden. Oral history can provide an

avenue for discovering new documentary sources and can help give new and deeper meaning to documentary sources that are already known.

For all this, oral history has not been without its critics, and there were methodological issues associated with oral history that had to be considered in preparing for this study. One of the main concerns was the degree to which subjects can accurately recall the past (Green & Troup, 1999, pp. 230-238; Perks & Thomson, 2006, pp. 211-220). Memories can be unreliable, and as such the validity of the evidence they provide has been called into question. Van der Dussen (1991, p. 155), for example, stated that “memories...are no part of historical knowledge”. The processes associated with human memory are not fully understood, nonetheless oral historians must recognise the fallibility of memory, and understand that memory appears to be an active and social process, dependent upon comprehension and interest (Thompson, 2000, pp. 128-134). Memories are influenced by interactions with others, and often reflect popular beliefs and social myth (Schrager, 1998; Thomson, 2006).

A second criticism levelled at oral history involves the relationship between the interviewer and the interviewee, specifically the influence that the interview as a social relationship has on the material collected through it (Thompson, 2000, pp. 137-143). There can be little doubt that the relationship between interviewer and interviewee can act as a source of bias. Interviewees might well respond to what they perceive to be the expectations of the interviewer and to any intended audience. They will not wish to look foolish. They might wish to protect themselves or others. Efforts must therefore be made to understand and to try to avoid bias. The task of the interviewer is to facilitate rather than lead. He or she should try to avoid unnecessary expression of his or her thoughts and views, even through body language, during the interview process. Having said this, there is a balance to be had, and the relationship must not be so clinical as to restrict self-expression.

Whereas issues of memory and the nature of the interviewer-interviewee relationship almost certainly present the strongest challenges to the credibility of oral history, there were other practical issues to consider in using interviews to help understand the professionalisation of chiropractic in Britain. Firstly, in view of the longevity of subjects, it was only possible to meaningfully examine the recent past. It was not possible to examine the pre-World War II period in any depth via interviews. Instead, first hand accounts of the period prior to World War II had to come from documents. Secondly, it was only possible to interview a small number of subjects, raising questions of selection bias and representativeness (in relation to others who might have been chosen for interview). Thirdly, the researcher had to become

proficient in appropriate techniques prior to undertaking key interviews, so as to maximise the likelihood of obtaining relevant information. In this regard a background of interviewing patients in clinical practice proved valuable.

2.2 Study design

During the first year of investigation a preliminary literature search was undertaken in order to identify accessible documents relevant to the broad area of interest. Having studied the material obtained following the preliminary literature search, having undertaken contextual studies in history and sociology, and following a series of discussions with peers and supervisors, the broad focus of interest was refined to a more precise topic for study.

An initial series of interviews with six academics, including two historians, two sociologists, and two chiropractors, provided an opportunity to increase understanding of the field, formulate research questions, identify sources, and generally orientate the work. The initial series of interviews also provided an opportunity to refine interview techniques. The initial interview series was not intended to provide evidence to directly inform the thesis. Each interview was recorded onto minidisc, but they were not transcribed in full. Instead, after each interview the recording was replayed and its contents considered. Written notes were made identifying key points and ideas, and these were used to help frame and guide the research.

An in-depth search for literature was initiated in the second year of the study. Databases searched included AMED, Copac, ICL, MANTIS, PubMed and the Web of Science. MeSH terms were used where appropriate. Table 2 provides a list of key terms drawn upon.

Searches were limited to articles written in English, but no temporal bounds were applied. The search terms used varied between databases in order to achieve best results, and terms were frequently combined. For example, one particular keyword search of AMED for the term 'chiropractic' was carried out on 27th October 2002 and produced 4,625 hits. By combining the terms 'chiropractic' and 'history' this number was reduced to 452, a more manageable number of citations. These were then examined on an individual basis and the list of citations filtered according to relevance. In this case it was recognised that the word 'history' had a dual meaning and that it referred to the process of gathering information from a patient by asking questions, as well as to the examination of the past. Many of the hits referred to reports of case studies in which patient histories were presented. In general, these were not considered to be directly relevant to the study of chiropractic's professionalisation

Table 2: List of key terms used during the literature search

<p><u>MeSH terms:</u></p> <p>Under 'Therapeutics' (E02): Complementary therapies; Musculoskeletal manipulations</p> <p>Under 'Health Occupations' (H02): Chiropractic; Osteopathic medicine; Orthopedics; Physical therapy</p> <p>Under 'Social Sciences' (I01): Sociology, medical; hierarchy, social</p> <p>Under 'History' (K01.400): History; History of medicine</p>
<p><u>Non-MeSH terms:</u></p> <p>Alternative Medicine; Osteopathy; Profession; Professional; Professionalization; Professionalism; Professional socialization</p>

in Britain and the full articles were not retrieved. Of those citations that focused on study of the past, an assessment was made as to their relevance. Where in doubt, the full articles were obtained and examined.

It is notable that only a small number of chiropractic journals were indexed on PubMed. This may say something of the quality of chiropractic journals, but it may also say something about the relationship between chiropractic and orthodox medicine.

The focus of research gradually progressed from identification of secondary sources, to identification of primary sources; and from identification of easily accessible literature, to identification of grey literature, documents written for restricted audiences and those outside traditional bibliographical controls (Hart, 2001, pp. 94-106). As well as chiropractic sources, a variety of other sources were examined. Having identified different sets of actors whose literature it was appropriate to study, such as medical doctors, osteopaths and UK government departments, pertinent repositories of literature were identified and explored. Research was undertaken at more than a dozen libraries and archives in the United Kingdom (Appendix 1). Specific repositories were chosen because of what it was thought they might offer, rather than their locational convenience. For instance, the National Archives at Kew were visited in order to study papers relating to the Looker College of Osteopathy and Chiropractic (a school that existed in Manchester, and later in London, during the 1920s);

papers relating to the British Health Freedom Society (with which chiropractors were involved subsequent to World War II); and papers relating to the British Chiropractors' Association's attempt during the 1970s to have the provisions of the *Professions Supplementary to Medicine Act* (Act of Parliament, 1960) extended to include them.

With an increasing amount of information becoming available via the Internet during the course of the study, online searches were performed, for example of periodicals such as the *British Medical Journal* and the *Lancet*, and of newspapers such as *The Times* and *The Guardian*. In cases where periodicals had not been indexed, it was sometimes necessary to undertake manual searches of individual issues, for example of *Background, Contact* and the *European Chiropractic Bulletin*. Relevant Parliamentary papers were examined at the University of Southampton, as were the contents of a number of private documentary collections. The processes employed in collection and analysis of documentary data were complex and iterative, involving a series of explorations based on problems and leads. Attention was paid to assessing the authenticity, credibility, representativeness, and meaning of documents. Cross-referencing was undertaken. As work progressed new research questions emerged. Throughout the process of investigation every reasonable effort was made to be thorough and systematic.

In view of the fact that there had been no co-ordinated effort to protect and bring together chiropractic historical documents in Britain, a decision was made to establish an historical library at the Anglo-European College of Chiropractic. The 'History Library' was officially opened on 7th March 2003. Through a series of articles and presentations potential contributors were informed of the Library's existence, and requests were made for documentary donations (Wilson, 2002, 2003b, 2003c, 2005b; Vall, 2003). The Library's focus on books, periodicals and papers associated with the history of Anglo-European chiropractic meant that it became a valuable resource for the study of chiropractic's professionalisation in Britain, but its contents were insufficient to provide the necessary contextual understanding of chiropractic's development, or of the detailed development of each of the different branches of chiropractic in Britain.

A particular problem associated with the literature search was identifying documentary sources for the period prior to 1925, the period before the British Chiropractors' Association came into being. Having become aware of the existence of pertinent material in the United States, field work was undertaken in Illinois, Iowa and Missouri during the summer of 2004. In order to identify chiropractic and osteopathic sources, data were obtained from libraries

and archives at the Palmer College of Chiropractic, the National University of Health Sciences, Kirksville College of Osteopathic Medicine, and Burlington Public Library. Unfortunately there were gaps in knowledge relevant to the study that could not be filled. I was unable to locate a copy of the first code of ethics of the British Chiropractors' Association, for example, and therefore was not in a position to analyse its contents. Neither was I able to obtain details of the internal debates which may have proceeded drafting of the code of ethics, or of the complaints against chiropractors which may have established a need for that code.

As a means of supplementing documentary evidence, a series of interviews to provide oral testimonies was planned. Whereas the initial interview series was intended primarily to 'guide' the research and identify questions, the main series of interviews was intended to provide answers to research questions and to increase historical awareness. Purposeful sampling (also known as 'purposive' sampling) was used in the selection of the interviewees (Patton, 1990, pp. 169-186; Low, 2007, p. 76). That is to say that subjects were consciously chosen because of their particular knowledge in relation to research questions. Personal understanding, documentary sources, and feedback from the preliminary series of interviews were utilized to identify a list of people for interview. Specific persons were chosen for interview because it was thought that they would be 'information-rich' about events and issues of vital importance to the understanding of chiropractic's professional development in Britain. In this respect it was judged particularly important to focus on the development of education and research in chiropractic, and on the discussions and events that directly preceded the *Chiropractors Act*. Ten individuals considered best able to shed light on these aspects of chiropractic's professionalisation were approached for interview. For example, Alan Breen was approached primarily because of his personal involvement in, and knowledge of, the development of chiropractic research in Britain, and also because of his experience as a chiropractic educator. It was anticipated that he would be able to shed light on the development of these fields. David Lidington MP was approached because he had introduced the Private Member's Bill to Parliament that became the *Chiropractors Act*. It was envisaged that he would be able to offer insight into the history of chiropractic statutory regulation. In addition a further six individuals were approached for interview with the object of increasing contextual understanding of chiropractic's professionalisation. To this end, two medical doctors, two physiotherapists, an osteopath and a Scottish chiropractor agreed to be interviewed. It was recognised that the Scottish Chiropractic Association had been set up in 1972 to provide a "local response to local problems" (Scottish Chiropractic Association, 1987). Stuart Wight, one of the founder members of the Association, was interviewed with the aim of better understanding Scottish perspectives on the professional

development of chiropractic in Britain. John Matthews was chosen because, as a physiotherapist who practised in the private sector, he had worked in direct competition with chiropractors, but he did not identify himself with chiropractic, thus providing an alternative viewpoint to my own. In all, sixteen potential interviewees were approached for the main series. Of these fifteen agreed to be interviewed and one provided a written testimony. Appendix 2 presents a list of interviewees, the dates of interviews, and a summary of the reasons for each interview.

The approach chosen to provide oral testimonies was one-to-one, qualitative, semi-structured interviewing. This approach was preferred to 'focus groups' for three main reasons. Firstly, the intention in selecting interviewees was not to select a 'sample' of subjects representative of a single population, but instead to interview individuals in respect of their independent expertise and lived experiences. Secondly, it was considered that collective memories of the past and nostalgia might play a more significant part in group discussions than in one-to-one interviews, with the effect of distorting historical truth and suppressing the private memories of individuals who might otherwise add valuable insight. Thirdly, in view of the subjects chosen, it was considered impractical to bring interviewees together for group discussions. A number of interviewees were elderly and interviewees lived a considerable distance from one another. Semi-structured, rather than structured interviews, were chosen in order to allow exploration of the subject matter that would otherwise not be possible, as it was anticipated that interviewees might have relevant information that had not been foreseen prior to interview. Interviews were planned so as to reflect the specialist knowledge of individual subjects, so that every interview was different.

Fundamental to the process of collecting oral evidence was the application of appropriate ethical principles. The aim was to protect the rights of the subjects being interviewed in relation to such issues as informed consent and data protection. Advice was sought from the Oral History Society and from the British Library's National Sound Archive. Ethics approval for the main series of interviews was granted by the Research Ethics Subcommittee at the AECC in July 2003, and by the University of Southampton in December 2007.

Initial contact was made with potential interviewees by telephone, or in writing, as was most convenient and appropriate in individual circumstances. Having agreed in principle to take part in the study, potential interviewees were asked to read a participant information sheet and complete a consent form (Appendices 3-4). The participant information sheet was intended to provide subjects with sufficient information in order for them to be able to make

an informed judgement as to whether they wished to take part in the research. The aims of the study were also discussed with each participant. Subjects were permitted to withdraw from the study at any stage, without giving a reason, as stated on the participant information sheet. Consent was obtained in writing from all subjects prior to interview.

In the lead up to each interview an ‘interview guide’ (Thompson, 2000, pp. 224-232; Bryman, 2001, pp. 314-321) specific to that interview was produced outlining themes and questions to be included, but this was not rigidly adhered to, providing a framework for each interview, whilst at the same time allowing for flexibility within the interview process. An example of an interview guide used in the course of the study is provided in Appendix 5. During interviews an empathetic approach was taken, but a deliberate attempt was made not to unduly influence answers. An endeavour was made to avoid leading questions. Non-directional prompts were used to urge response, for example, there were occasions when the interviewer was deliberately silent in order to encourage the interviewee to speak. Each interview was recorded onto minidisc. Data were then stored in a secure environment. In the long run, with the permission of interviewees, it is anticipated that oral testimonies from the doctoral study will be lodged in the History Library at the AECC. Otherwise, recordings and transcripts are to be destroyed.

Each interview in the main series was transcribed in full. In analysing the data obtained from oral testimonies, in view of the unique subject matter associated with each interview, no attempt was made to collectively classify or code data. Instead, individual interviews were examined for key emergent themes and relevant pieces of information. Once highlighted, these were reflected upon in the context of data from documentary sources. In analysing and interpreting data from oral interviews the fallibility of memory was taken into account. It was noted, for example, that dates recalled at interview were sometimes at odds with documentary evidence.

Data from oral testimonies directly informed the thesis, and the names of interviewees have, with their permission, been included in this dissertation. Where the comments of interviewees have been referred to in the text, the interviewees were re-contacted to verify the accuracy of the representation of their statements. As well as helping to answer research questions, the main series of interviews imparted fresh perspectives on the understanding of chiropractic’s professionalisation in Britain, and helped in the identification of further documentary sources. As it turned out, the value of interviews exceeded initial expectations. Whereas it was thought that interviews were likely to be worthwhile in providing evidence in respect to the thesis, and helpful in directing the search for documents, the extent to which

they would deepen historical awareness was not fully appreciated. Even taking into account issues of memory and the social relationship between interviewer and interviewee, listening to the lived experiences of subjects provided depth of understanding that would not have been achieved otherwise. The interviews ‘connected’ the researcher to the history and so enhanced the writing of the thesis.

2.3 Architecture of the thesis

During the course of the research, through analysis of documentary and oral data, a series of natural temporal divisions became apparent through which the dissertation could usefully be divided into chapters. Within each time period, attention was paid to the most appropriate themes to be included, so as to produce a fair and balanced view of chiropractic’s history, based on the emergent understanding. Thus:

- Chapter 3 examines the origins of chiropractic and the early development of chiropractic in the United States, providing essential historical background for subsequent discussions, and challenging the traditional assumption that chiropractic was “discovered” by Daniel David Palmer in September 1895 (The Chiropractor, 1904a; Palmer, 1910, p. 1 & pp. 17-19). The early history of chiropractic in the United States is relevant to the thesis because of its marked influence on the development of chiropractic in Britain. The question of what exactly chiropractic is, is raised by its early North American history.
- Chapter 4 explores the historical context, antecedents and origins of chiropractic in Britain. It is argued that chiropractic was not simply an import from the United States and that similar practices already existed in Britain before individuals first chose to describe themselves as chiropractors. In Britain, in the early part of the twentieth century, the distinction between chiropractor, osteopath and bonesetter was poorly defined.
- If chiropractic was to professionalise in Britain it had to develop a coherent identity that would differentiate it from osteopathy and bonesetting. In the years between World War I and World War II, the subject of chapter 5, chiropractors organised themselves and the British Chiropractors’ Association (later to become the British Chiropractic Association) encouraged differentiation. The first schools purporting to

teach chiropractic in Britain, all of which were short-lived, came into existence. The British Chiropractors' Association published a code of ethics for its members.

- The years between 1939 and 1965 are the subject of chapter 6. The Second World War is seen as a watershed in the evolution of British chiropractic. Chiropractic's development was seriously hampered by the War and further threatened by the formation of the National Health Service in 1948, but in the post-War period chiropractors reorganised themselves and the British Chiropractors' Association came to the fore as a mouthpiece for chiropractors practising in Britain. Traditional values and ideas were questioned. Medicalisation of chiropractic began in earnest. Collective action resulted in the opening of the Anglo-European College of Chiropractice (later known as the Anglo-European College of Chiropractic) in 1965.
- Chapter 7 examines the years following the establishment of the Anglo-European College of Chiropractice, a period that saw the emergence of McTimoney Chiropractic as a distinct branch of chiropractic in Britain, and also an unsuccessful attempt by the British Chiropractors' Association to have chiropractic included under the provisions of the Council for Professions Supplementary to Medicine.
- Between the late 1970s and 1994, the interval examined in chapter 8, a progression towards professional maturation took place within British chiropractic that culminated in the *Chiropractors Act*. In spite of ideological differences between chiropractors and between different chiropractic groups, in the cause of statutory regulation an image was presented to strategic elites of intra-occupational organisation and unity, of a willingness to ground chiropractic in science, and of chiropractic as complementary to medicine.
- In chapter 9 a sociological analysis of the *Chiropractors Act* is undertaken, and the years between the Act and the advent of legal protection of title are examined. The professionalisation of chiropractic in Britain continued, for example through the development of educational links with the university sector.
- The discussions and arguments contained within preceding chapters are drawn together in chapter 10, the final chapter of the thesis. Judgements are made as to what was achieved by chiropractic through professionalisation and related processes

in the years leading up to 2001, what was not achieved, and why. The legacy of this period of history is appraised.

CHAPTER 3

The Origins of Chiropractic and its Early Development in the United States

The traditional story of the origin of chiropractic, the story popular amongst chiropractors today, tells of how chiropractic was ‘discovered’ by Daniel David Palmer, in Davenport, Iowa, in 1895. Although the precise date of the first chiropractic adjustment has been questioned (Keating, 1993), Palmer himself informs us that “chiropractic had its beginning in September 1895” (Palmer, 1910, p.101), and that he was (Palmer, 1910, p. 1):

The one who discovered the basic principle of chiropractic, developed its philosophy, originated and founded the science and art of correcting abnormal functions by hand adjusting, using the vertebral processes as levers.

The word ‘discovered’ implies, or might be seen to imply, that Palmer was the first to come to know the fundamental doctrine that underpinned chiropractic. It implies, or might be seen to imply, as Gielow (1981, p. 77) put it, that Palmer had a moment of “intellectual enlightenment or revelation”. In this chapter it is argued that this was probably not the case, and that Palmer’s chiropractic was instead, wittingly or unwittingly, built upon the ideas of others. It is argued that what the Palmers, Daniel David Palmer and his son Bartlett Joshua Palmer, were collectively responsible for was packaging and marketing a set of ideas and services that became known as chiropractic. Between them they promoted their vision of chiropractic so successfully as to lay central foundations for its subsequent development, not only in the United States, but also in the United Kingdom. Given this legacy, and the fact that the term ‘chiropractic’ was first applied to the practice of Daniel Palmer, special attention is given to the Palmers in the following discussion. It is pertinent to this thesis that Daniel Palmer’s vision of chiropractic ran contrary to the medical orthodoxy of its day.

3.1 The emergence of chiropractic: its antecedents and origins

Daniel Palmer’s chiropractic was not fully fledged in 1895 and his chiropractic theories continued to be modified until his death in 1913 (Keating, 2005b, p. 29-30). When his son Bartlett Palmer produced a book on chiropractic in 1906, Daniel Palmer objected to its publication because he did not consider chiropractic sufficiently developed (Palmer, 1910, p.

9). By 1910, however, Daniel Palmer was ready to present his vision of chiropractic to the world in his book *The Science, Art and Philosophy of Chiropractic* (Palmer, 1910).

Palmer's system of chiropractic beliefs included both natural and metaphysical elements. In this section the focus will first be on the history of the natural concepts of subluxation, spinal irritation and manipulation that underpinned Palmer's chiropractic; then on metaphysical notions that were incorporated into Palmer's philosophy of chiropractic; before turning specifically to magnetic healing, bonesetting and osteopathy, conceivably the most direct forebears of chiropractic, and thereafter to the chiropractic origin myth (the traditional, but perhaps not wholly accurate story of chiropractic's origin).

Fundamental to Daniel David Palmer's natural philosophy of chiropractic was the idea that abnormal displacements of spinal vertebrae called 'subluxations' (incomplete dislocations of joints), could result in compromise to the nerves that run through the spinal column (Palmer, 1910, pp. 17-19). When this occurred, it was believed that nervous communication with parts of the body was adversely affected, causing disease at sites distant from the spine. Manipulations or 'adjustments' applied to the spine could be used to correct vertebral displacements, reducing neurological compromise, returning nervous function to normal, and thus eliminating the cause of disease. Palmer did not claim to be the first to use spinal manipulation, nor did he claim to be the first to replace subluxated vertebrae. He did, however, claim to be the first to use the prominences of vertebrae, their spinous and transverse processes, as levers by which to return vertebrae to their normal positions (Palmer, 1910, p. 11).

Manipulation has ancient origins (Schiötz & Cyriax, 1975, pp. 5-14; Gaucher-Peslherbe, 1995; Wiese & Callender, 2005). For centuries before Palmer's time medical doctors, bonesetters and others had employed manual therapy in the treatment of patients with fractures, dislocations and other bony displacements. Manipulation had been a part of the tradition of organised medicine and also a part of the folk tradition of medicine. Manipulative skills had been taught within medical institutions and also passed on within families.

The word 'subluxation' probably has a seventeenth century origin. Watkins (1968) and Terrett (1987) have traced its use back to 1746, to a dissertation written by Hieronymi, entitled *De Luxationibus et Subluxationibus*, but the word 'sublaxation' [sic] was used by Holme in 1688 (Book II, p. 448) to describe "a dislocation or putting out of joyn". In the nineteenth century, in the years before Palmer's chiropractic, various authors referred to the

concept of subluxation. One of them was Harrison. In the 1820s Harrison (1820, 1821 & 1824) composed a series of articles about spinal disorders for the *London Medical and Physical Journal* in which he not only used the concept of the subluxation, but also described the possible effects of subluxation in a way remarkably similar to Palmer. He wrote (Harrison, 1820, p. 369):

A small irregularity in the height and disposition of some particular vertebrae is perceptible, on examination, in most delicate females. This disorderly arrangement and disposition of the component parts of the spinal column, though hitherto overlooked and wholly neglected, are, I am persuaded, of great consequence to future health. The effects of this subluxation, not being distinguishable by the symptoms, have never been traced to their origin in the spine. A very slight and partial compression of the cord, or some of its nerves, will disturb the organs to which they run.

Further (Harrison, 1821, p. 113):

According to this view of the subject, the obvious indication for the care of spinal affections consists of restoring the displaced bones to their natural situations, that the spinal cord and its nerves, relieved from injurious pressure and disturbance may be re-instated in their former abilities. In all the cases hitherto treated agreeably to these principles, the success has been complete. The affected organs to which they run, being no longer under the influence of diseased nerves, gradually recover their healthy state and proper functions.

Harrison treated cases where (in his opinion) subluxations existed through a combination of therapies that included rubbing, spinal traction and spinal manipulation (Harrison, 1824). According to Little (1868, p. 57), Harrison did what Palmer stated that no one before him had done – he used the spinous and transverse processes of vertebrae as levers by which to correct vertebral misalignments.

Harrison made the link between subluxations and diseases of organs a quarter of a century before Palmer's birth. What is more, he came to the conclusion that organic diseases could result from spinal disorders, rather than *vice versa*. Others followed in a similar vein. For example, Player, who may not have been familiar with Harrison's writings, wrote about the possible implications of "irritation of spinal nerves" in a letter to the *Quarterly Journal of Science, Literature, and the Arts* (London), published in 1822. The expression "spinal irritation" was probably coined by Brown, and appeared in an article published by the *Glasgow Medical Journal* in 1828. Teale, who was familiar with both Player's and Brown's work and held similar views to them on the matter of spinal irritation, produced a *Treatise*

on Neuralgic Diseases in which he discussed spinal irritation, that was published in London in 1829. During the 1830s Riadore lectured on the subject of nervous irritation (Riadore, 1835). In 1842 he produced a *Treatise of Irritation of the Spinal Nerves*. Articles on spinal irritation appeared in issues of the *Provincial Medical and Surgical Journal*, a forerunner of the *British Medical Journal* (Winter, 1841; Provincial Medical Journal, 1842; Morris, 1843; Favell, 1846). Within them spinal irritation was linked to conditions such as cough, fever, laboured breathing and disordered digestion.

That the concept of spinal irritation became a matter of debate in the United States as well as in Britain during the 1830s and 1840s is evidenced by the fact that a number of pieces were published in the *American Journal of the Medical Sciences* between 1832 and 1842 (Parrish, 1832; Malone, 1835; Marshall, 1836; American Journal of the Medical Sciences, 1836; Annan, 1837; American Journal of the Medical Sciences, 1842a; American Journal of the Medical Sciences, 1842b). It is also of note that Teale's treatise, originally published in England, was republished in Philadelphia in 1830.

Is it conceivable that Palmer was unfamiliar with all of this work? This question matters with respect to how we judge Palmer, whether we view him as the 'discoverer' of chiropractic, a person who unconsciously imbibed the ideas of others and made them his own, or as a dishonest charlatan. It is certainly possible that Palmer did not have first hand knowledge of this work, for these writers were not his contemporaries, however ideas about spinal irritation espoused in the first half of the nineteenth century remained a matter of discourse in the second half of the century. Hammond's *Treatise on the Diseases of the Nervous System*, for example, published in the United States in nine editions between 1871 and 1891, included discussion on spinal irritation. As a matter of fact, more than twenty pages were given over to it in the ninth edition (Hammond, 1891, pp. 374-397). Although Palmer might not have been familiar with the earliest writings on the subject of spinal irritation, there is reason to believe that by 1906, if not before, he was acquainted with the concept, for spinal irritation was specifically referred to in *The Science of Chiropractic* (Palmer & Palmer, 1906, p. 71), and later in *The Science, Art and Philosophy of Chiropractic* (Palmer, 1910, pp. 206-207).

It should be stated that spinal irritation was never a central tenet of medical orthodoxy. Hammond tells us that the great mass of the medical profession treated the theory of spinal irritation with suspicion (Hammond, 1891, p. 381). On the whole, even those who accepted the theory did not see spinal affections as the key to understanding all, or nearly all diseases. In this respect Palmer was different, for he stated (Palmer, 1910, p. 56):

A subluxated vertebra, a vertebral bone, is the cause of 95 per cent of all diseases... The other five percent is caused by displaced bones, other than those of the vertebral column, more specifically those of the tarsus, metatarsus and phalanges [the bones of the foot], which by their displacement are the cause of bunions and corns.

Palmer went further than most others. He made a bold and unorthodox claim as to 'the' cause of disease. Why did he do this? He may have genuinely believed subluxations to be 'the' cause of disease, for he asserted that his personal experiences had led him to this conclusion (Palmer, 1910, pp. 17-19), but it is also possible that his claims were made, in part at least, for practical reasons. Subluxation theory in the form proposed by Palmer was simple and appealing. It offered hope against disease, the promise of a panacea; but it must also be recognised that this was a business opportunity for Palmer, an opportunity that afforded not only the prospect of increased financial security for him, but also the making of his name. Palmer had a head for business. He was a practical person who had sought to make a living for himself and his family through a variety of means. He had had business experience in cultivating a nursery, keeping bees, running a grocery store, selling tropical fish and practising as a magnetic healer. It is hard to believe that he did not appreciate the commercial possibilities attendant on subluxation theory.

Palmer's version of subluxation theory stood in contrast to germ theory (the theory that micro-organisms caused disease), and in contrast to humoral theory (the traditional theory that it was an imbalance in humours – black bile, yellow bile, phlegm and blood – that caused disease). It provided for an alternative understanding of disease, one that became the foundation for an alternative healthcare practice.

In order for any alternative system of medicine to exist there must be a medical orthodoxy against which it can react, something for it to be alternative to (Bivins, 2007, p. 6). The alternative practice may be understood in terms of philosophical difference, such as an understanding of disease at odds with the dominant paradigm, but also in terms of social difference. In this regard the process of professionalisation of medicine which took place in the United States following the American Civil War is important. In 1865 the War ended with victory for the North. The years that followed saw urbanisation and industrialisation of the United States, expansion to the west and south, and a new national consciousness (Schlesinger, 1954, pp. 27-50; Tindall & Shi, 2004, pp. 759-928). North American society changed, and so did medicine. A transformation occurred within medicine through which the divide between orthodox and non-orthodox, between mainstream and alternative, became more clear-cut than in previous times. Starr (1982, pp. 81-85) informs us that prior to this

period a career in medicine was not considered prestigious in itself. Family background and the status of one's patients were generally viewed as being more important than the fact of being a medical doctor. In the absence of standardised educational requirements as a route of entry into medicine, it was not always obvious who was, and who was not, a medical doctor. The consolidation of medical authority that took place during the second half of the nineteenth century and continued into the first half of the twentieth century, saw the medical career become prestigious. The formalisation of medical education and statutory registration of medical doctors led to the emergence of a social partition between medical doctors and other healthcare workers. Palmer had had no formal training in medicine. It appears that he began to work as a healthcare practitioner in 1886 (Palmer, 1886). Had he been in practice just five years earlier he would in all likelihood have been able to successfully apply for a medical licence (Gielow, 1981, p. 105). As it was, in the state of Iowa where he lived for a good portion of his life, that opportunity was not open to him. He did not apply for registration as a medical doctor, and therefore, socially as well as philosophically, his practice of chiropractic was separated from medical orthodoxy. Palmer practised on the medical fringe, outside the confines of state law in Iowa.

Palmer lacked social solidarity with registered medical doctors because he himself was not registered as a medical doctor. He also lacked social solidarity with them because the beliefs and practices which he advocated were different, because subluxation theory in the form that he proposed was incompatible with germ theory. Either subluxations were 'the' cause of disease, or they were not. One could not reasonably believe in germ theory and at the same time accept Palmer's philosophy of chiropractic. Palmer's system of beliefs opposed medical orthodoxy and was reactive to its limitations, for if orthodox medicine had solved the problem of disease then there would have been no place for chiropractic.

It is important to recognise that the process of professionalisation of medicine that took place during the nineteenth century occurred concomitant with an increasing focus on science (Bynum, 1994, pp. 218-226; Porter, 1997, pp. 304-347; Bynum, 2006). Through the efforts of Bernard and others scientific method gradually became firmly established within medicine, and through biomedical research undertaken by individuals such as Pasteur and Koch new medical knowledge was produced. The aggressive therapies that had been used by doctors in the eighteenth and early nineteenth centuries, which came to be known as 'heroic medicine', were gradually replaced by more modern methods. The idea that active intervention and strength of remedy should be in proportion to the severity of disease was widely rejected. Those patients who were most severely ill were no longer given the most aggressive forms of treatment as a matter of principle. Doses of mercury and blood letting

were used less frequently than before. Humoralism became less popular. These changes, however, did not occur before the emergence of groups opposed to what they saw as medical excesses. During the nineteenth century Thomsonians, homeopaths and eclectics were prominent amongst those opposed to heroic medicine (Gevitz, 1993, pp. 604-616; Rothstein, 1995, pp. 40-42; Whorton, 2002, pp. 3-24). Their ideas tended to emphasise the healing power of nature, and they saw themselves as practising in harmony with nature, rather than exercising power over it. Thomsonians, who favoured the use of botanical remedies over mineral medicines, saw fever as an attempt by the body to rid itself of disease, and viewed endeavours by doctors to combat fever as misguided. Samuel Hahnemann, the father of homeopathy, whose system of infinitesimal doses might be seen as the antipathy of heroic medicine, believed that a vital spirit governed life. Eclectics, who as their name suggests took ideas from many schools, and who like Thomsonians often used botanical remedies, encouraged alignment with nature and the sustaining of the vital forces of the body.

In common with a good number of the opponents of heroic medicine, Palmer was an advocate of vitalism. He supported the notion that life could not be explained purely in terms of physical and chemical forces, and that a 'spirit' animated living beings. At various points during the development of chiropractic vitalism was emphasised to a greater or lesser extent by Palmer as part of his philosophy of chiropractic (Donahue, 1986; Morgan, 1998). Palmer had become attracted to spiritualism in the 1870s and like quite a few North Americans of his time he asserted that it was possible to communicate with the spirits of the dead. Spiritualism influenced his writings on chiropractic. In fact he went as far as to claim that much of his knowledge of chiropractic was the result of spiritual inspiration (Palmer, 1914, p. 5):

The knowledge and philosophy given me by Dr. Jim Atkinson, an intelligent spiritual being, together with explanations of phenomena, principles resolved from causes, effects, powers, laws and utility, appealed to my reason.

The method by which I obtained an explanation of certain physical phenomena, from an intelligence in the spiritual world, is known in biblical language as inspiration. In a great measure The Chiropractors Adjuster was written under such spiritual promptings.

Palmer's vitalism was possibly also influenced by study of Eddy's Christian Science and by aspects of the New Thought movement (The Chiropractic, 1899, p. 1). His vitalism was founded on the idea of a 'Universal Intelligence' and an 'Innate Intelligence' within each individual. Universal Intelligence was seen to be the life force of creation (equivalent of the

Christian concept of God), and Innate as an individualised element of spiritual intelligence. Palmer's understanding of Universal Intelligence was perhaps not dissimilar to the concept of 'Nous' (or 'Mind'), described by the pre-Socratic philosopher Anaxagoras, a unified cosmic intelligence and controlling force within individual living beings (Schofield, 1980, pp. 3-4). Palmer envisioned Innate as the vital force, or controlling intelligence that maintained health and oversaw reparative processes of the body. If Innate was able to effectively communicate with all parts of the body, which it did through the nervous system, normal function and health would prevail.

Did Palmer really believe that he had been visited by the spirit of Jim Atkinson? We cannot know. It is possible that Palmer genuinely believed that he had received spiritual inspiration. It is also possible that the story was made up in order to add an appealing air of mystery to chiropractic, and to provide Palmer with a supernatural endorsement. In either case, Palmer linked chiropractic to the fundamental forces and workings of the universe. He afforded it grandeur. Whatever his reasons, vitalism was superimposed upon Palmer's natural theory of subluxations. Whereas Palmer's subluxation theory was open to scientific scrutiny, the concept of Innate Intelligence was not. It was a metaphysical notion, an unverifiable and unfalsifiable assertion which science was unable to test. As systematic scientific investigation became increasingly valued within medical orthodoxy metaphysical ideas were increasingly rejected as grounds for medical practice. The idea of Innate Intelligence and its linkage to the clinically applicable theory of subluxations made the divide between Palmer's chiropractic and medical orthodoxy deeper than it might otherwise have been. Vitalism would become a contentious issue in chiropractic.

According to Gevitz (1993, p. 620), magnetic healing was the "intellectual progenitor" of chiropractic. It is known that Palmer first entered the field of healthcare as a magnetic healer in Burlington, Iowa, and that he practised as a magnetic healer in Burlington, and later in Davenport, before making his transition to chiropractic (Beck, 1991). In the eighteenth century the Austrian physician Mesmer had proposed that there was a magnetic fluid, or force, that filled the universe and that took concentrated form in the human and animal body (Gevitz, 1993, pp. 620-621; Morgan, 1998). In order for an individual to be healthy a balance in magnetism was required in all parts of the body. If the balance was disrupted then disease resulted. Mesmer believed that balance could be re-established in an unhealthy individual by use of the hands and by use of magnets. Whereas magnetic healing techniques often involved the practitioner passing his or her hands over the patient without touching the body, they also sometimes involved direct physical contact with the patient, such as rubbing or holding. Andrew Jackson Davis, for example, who like Palmer was a proponent of both

spiritualism and magnetic healing, encouraged use of physical manipulations for conditions such as asthma (Davis, 1855, p. 327). According to Livezey (*The Magnetic Cure*, 1896), Palmer's approach to magnetic healing involving holding his fingers over a diseased organ or organs, rather than rubbing or stroking. That being the case, it is reasonable to assume that Palmer's therapeutic focus on the organ, rather than on its nervous innervation, distinguished his magnetic healing practice from his chiropractic practice.

It is conceivable that the initial inspiration for Palmer's decision to become a magnetic healer was Paul Caster, who, having taken up the art in the 1860s, had established a successful magnetic healing practice in Ottumwa, Iowa. Both Carver in his *History of Chiropractic* (circa 1936, p. 5), and Daniel Palmer's son Bartlett Palmer in *Fight to Climb* (1950, p. 58), tell us that Palmer received instruction from Paul Caster, however, according to the *Biographical Review of Des Moines County, Iowa* (1905, p. 230) Paul Caster died in 1881 and Palmer's daybook suggests that he did not treat his first patient until 1886 (Palmer, 1886). It is perhaps less important to this thesis how Palmer came to be a magnetic healer than the fact that he did. The *Burlington City Directory* of 1887 (p. 267) includes the name "Palmer, D.D.", under the heading "physicians" and the subheading "magnetic".

As well as Palmer's name, the names of thirty-three other individuals are to be found in the *Burlington City Directory* of 1887 under the heading "physicians" (p. 266-267). Of these twenty-five were recorded as "allopathic", three as "eclectic", three as "homeopathic", one as "oculist", and one as "botanic". It seems likely that Palmer might have been broadly familiar with the work of some of these individuals and that he might have been influenced by one or more of them. There can be little doubt that his experiences as a magnetic healer would have influenced him. Palmer may also have been familiar with the work of a particular group of bonesetters resident in the Midwestern United States, immigrants from Bohemia, who called their practice 'napravit' (meaning 'to rectify'). Palmer might have learnt manipulative techniques from one or more members of this group (see: Bovine, 2011). It is conceivable, however, that the most important influence on Palmer in his evolution from magnetic healer to chiropractor was the self-proclaimed 'lightning bonesetter' Andrew Taylor Still, traditionally recognised as being the founder of osteopathy.

Still had practised as a medical doctor, but he became disillusioned with the medical remedies of his day following the death from meningitis of three members of his family, two of his own children, and one adopted child (Still, 1897, pp. 98-101). A person of religious faith, the son of a Methodist preacher, he wondered why in sickness God appeared to have left humanity guessing. He sought a better understanding of disease, and came to the

conclusion that an intelligent maker had deposited within each human body an inherent ability, and sufficient drugs, to cure all infirmities. In order for the body's own "drug-store" (Still, 1897, p.101) to be effectively administered where and as necessary, vascular pathways and nervous infrastructure had to be functioning normally. If these were compromised, as he believed often occurred in the presence of vertebral misalignments, then the internal mechanisms of the body designed to combat disease could fail. The duty of the clinician was to remove obstructions to the body's own inherent healing mechanisms by means of adjustments to its framework.

Still informs us that in 1874 he "flung to the breeze the banner of Osteopathy" (Still, 1897, p. 108). Still's osteopathy pre-dated Palmer's chiropractic and shared much in common with it. Both Still's osteopathy and Palmer's chiropractic advocated the use of manipulation to remove mechanical obstructions that were considered to result in disease. Whereas Palmer focused on obstructions to nervous communication, Still also emphasised the importance of adequate blood flow. The *Journal of Osteopathy* (1897a) defined the fundamental principles of osteopathy as follows:

- 1st – That health is natural; disease and death, between the time of birth and old age, unnatural.
- 2nd – That all bodily disorders are the result of mechanical obstruction to the free circulation of vital fluids and forces.

Still opened a school of osteopathy in Kirksville, Missouri in 1892 (Walter, 1992, p. 1). Some early osteopathic literature implied not only that Palmer was influenced by Still's teachings, but that his chiropractic was, to all intents and purposes, stolen from osteopathy. For example, in the *Journal of Osteopathy* (1897b) it was asserted:

There is one fake magnetic healer in Iowa who issued a paper devoted to his alleged new system, and who until recently made up his entire publication from the contents of the *Journal of Osteopathy*, changing it only to insert the name of his own practice.

In *The Lengthening Shadow of Dr. Andrew Taylor Still* (1938, pp. 44-45), Hildreth stated:

At the opening of the second class in the fall of 1893, a man by the name of Strothers who had been a member of the first class in the fall and winter before and who had been practising a little at Davenport, Iowa, during the summer of 1893, returned to Kirksville for further study. There came with him a man who said his name was Palmer. The person, probably in his fifties, was a large, heavy man with a dark brown beard. He came to Kirksville, it was said, to take treatment from Dr. Still. Dr. Still's daughter Blanche, now Mrs. George M. Laughlin, told me that this man

Palmer was not only treated by my father, but also sat at the family table upon the invitation of the old Doctor...Palmer took treatments from Still for a few weeks. He also talked with Dr. Still's students, and was treated by many of them. When we next heard of him, he has "discovered" a method of treating disease by hands, which he called chiropractic.

It is not known for certain whether Palmer visited Still in the years prior to his movement into chiropractic, or the extent to which he was influenced by Still, by osteopathic writings, or by Still's followers. It is worthy of note, however, that prior to Hildreth's account, Gregory (1912, p. XXX), who had studied chiropractic under Palmer and who later set up a school with him, had claimed that Palmer had "obtained his first ideas of spinal lesions from an osteopath by the name of Struthers" [sic]. It is possible that Palmer's conceptualisations were developed independently of Still and his followers, but it seems likely either that osteopathy acted as an inspiration to Palmer, or that Still and Palmer were influenced by similar things. Either way, the originality of Palmer's thought is again called into question, as is his self-proclaimed position as the 'discoverer' of chiropractic.

Chiropractic was given its name by one of Palmer's patients, the Reverend Samuel Weed (Palmer & Palmer, 1906, front matter, unnumbered page), from the Greek 'chiro', meaning 'hand', and 'praktikós', meaning 'concerned with action'. Palmer presented what is generally considered to be the classic account of the first chiropractic adjustments in his book *The Science, Art and Philosophy of Chiropractic* (Palmer, 1910, pp. 18-19). Although quite long, the following extract is considered to be of sufficient importance to be included here:

One question was always uppermost in my mind in my search for the cause of disease. I desired to know why one person was ailing and his associate, eating at the same table, working in the same shop, at the same bench, was not. **Why?** What difference was there in the two persons that caused one to have pneumonia, catarrh, typhoid or rheumatism, while his partner, similarly situated escaped? **Why?** This question had worried thousands for centuries and was answered in September 1895.

Harvey Lillard a janitor in the Ryan Block, where I had my office, had been so deaf for 17 years that he could not hear the racket of a wagon on the street or the ticking of a watch. I made inquiry as to the cause of his deafness and was informed that when he was exerting himself in a cramped, stooping position, he felt something give way in his back and immediately became deaf. An examination showed a vertebra racked from its normal position. I reasoned that if that vertebra was replaced, the man's hearing should be restored. With this object in view, a half-hour's talk persuaded Mr. Lillard to allow me to replace it. I racked it into position by using the spinous

process as a lever and soon the man could hear as before. There was nothing “accidental” about this, as it was accomplished with an object in view, and the result expected was obtained. There was nothing “crude” about this adjustment; it was specific, so much so that no Chiropractor has equalled it...

Shortly after this relief of deafness, I had a case of heart trouble which was not improving. I examined the spine and found a displaced vertebra pressing against the nerves which innervate the heart. I adjusted the vertebra and gave immediate relief - nothing “accidental” or “crude” about this. Then I began to reason if two diseases, so dissimilar as deafness and heart trouble, came from impingement, a pressure on nerves, were not other diseases due to a similar cause?

From this account it might be understood that Palmer assumed there to be a single cause of disease, and that he believed that he had found that cause and its cure in September 1895. The message that Palmer appears to have wanted to get across was that his initial chiropractic treatments were precise and orchestrated, and that the quality of his first chiropractic adjustment was second to none. Palmer’s account is arguably much more than a factual report of events, for Palmer presents himself in a particularly positive light as the ‘discoverer’ of chiropractic, and as its authority. This account might be seen as an attempt by Palmer to create a chiropractic ‘origin myth’ around himself, when in reality chiropractic was instead the product of a complex evolution. In view of the fact that Palmer’s chiropractic had similarities with pre-existing practices, ‘product differentiation’ might have played a part in Palmer’s attempt to distinguish himself as the originator of the set of ideas and practices that he called chiropractic. Other accounts of Palmer’s treatment of Harvey Lillard have implied that Lillard’s cure was rather more accidental than Palmer was prepared to admit (Carver, circa 1936, pp. 5-8; Gielow, 1981, pp. 78-79; Westbrooks, 1982).

In the foregoing discussions I have attempted to convey the idea that there was rather more to the origin of chiropractic than some traditional accounts might have us believe. Rather than chiropractic being ‘discovered’ by Palmer in a moment of enlightenment, there is reason to believe that his philosophy and his practice were derived, consciously or unconsciously, to a greater or lesser extent, from pre-existing ideas and approaches. Palmer’s chiropractic represented a union of natural and metaphysical ideas, the product of a web of influences. It is not possible to know every aspect of that web, so as to understand the precise degree of influence that each antecedent of chiropractic had upon Palmer. It is not possible to know every detail of the mechanisms through which Palmer’s chiropractic emerged. Palmer lived at a time and in a place where new theories and ideas abounded. His chiropractic was a product of that complexity. It is important to note that Palmer’s combination of scientifically testable ideas with metaphysical, scientifically untestable ideas,

provided for a mixed legacy for chiropractic that would influence the occupation's relationship with the medical profession both in United States and Britain, and would have significant implications for its professionalisation in both countries.

3.2 The growth of chiropractic in the United States

In order for an alternative system of medicine, such as chiropractic, to flourish within a society a particular set of circumstances are necessary. Firstly, there must exist a sufficiently distinct and appealing body of ideas and theories by which the alternative medical system can be defined. Secondly, there must be a favourable medical and socio-political climate for cultivation of the alternative medical system. There must, for example, be a medical orthodoxy to be alternative to, and that orthodoxy must have been found wanting by a portion of the society such that there is a market for the specific medical alternative (this should not be taken to imply that the orthodoxy must at any point have been wholly unquestioned). Thirdly, although it is possible for medical groups with distinct social identities to prevail within societies in the absence of appreciable formal organisation (for example nineteenth century bonesetters practising in Europe and North America, whose collective identity was largely the product of informal networks), formal organisation and effective leadership are generally to be regarded as advantageous to the successful development of alternative medical systems. Furthermore, formal organisation is a necessary part of professionalisation.

The core body of suppositions that defined Palmer's chiropractic have already been described, and it is recognised that a potentially favourable seedbed for the development of chiropractic existed in the United States in the late nineteenth and early twentieth centuries, for universal contentment with medical orthodoxy was lacking and there existed an openness to new medical ideas. Attention is now turned to the initial organisation, growth and professionalisation of chiropractic in the United States.

By 1897 Daniel David Palmer's paper that had previously been called *The Magnetic Cure* became *The Chiropractic*. Palmer had begun to advertise himself as a chiropractor with a view to attracting chiropractic patients, but he also advertised for students of chiropractic. This was the case even though his ideas about chiropractic were not yet fully fledged. He wrote (*The Chiropractic*, 1897, p. 1):

\$500 will get you an education in three months which will better fit you for a healer of diseases, than any medical education in the world.

It is estimated that \$500 in 1897 had the equivalent purchasing power of between \$10,000 and \$15,000 today (Officer & Williamson, 2010). This was not an insubstantial sum of money for a three month course. For Palmer to make a success of his chiropractic ventures, his clinical practice and his teaching, it was in his interest to project a positive image of himself and of his methods. Macdonald (1989) has highlighted the importance of buildings as symbols of status and respectability. Palmer's offices were centrally located in Davenport, on the fourth floor of the prominent Ryan Building. Initially, when he had first moved to Davenport in the late 1880s, he had rented three rooms in the building, but by 1896 his 'infirmary' occupied the whole of the fourth floor. This enabled Palmer not only to house his clinical practice, but to also offer board to patients. H.J. Parker, a bookkeeper for B.R. Grain Company, who worked in the Ryan Building, stated (The Magnetic Cure, 1896, p. 3):

Eight years ago Dr. Palmer came here and rented three rooms. We then thought him a humbug, and that it would only be a short time till his rooms would be vacant and he departed; but instead we have been happily surprised to see his practice steadily increase, until he is now occupying 42 rooms for his business and the accommodation of patients who come from a distance.

In spite of the establishment of what appeared to be a successful clinical practice in Davenport, it is worthy of mention that in 1896 Palmer was still advertising that he sold tropical fish (The Magnetic Cure, 1896, p. 1). According to his book, *The Science, Art and Philosophy of Chiropractic* (p. 468), he taught one chiropractic student in 1898, three in 1899, two in 1900, five in 1901, and four in 1902, amongst them his son Bartlett Palmer. These were small numbers. Oakley Smith was critical of the chiropractic instruction that he received from Palmer in 1899 (Smith, 1932, pp. 5-6):

A few days before I was 19 my tuition of \$500.00 was paid for a course of instruction in Chiropractic. The first thing I learnt was that there was no instruction to be given. There were no blackboards, no text books, no notes, not a single lecture. For six days I witnessed the giving of a number of treatments. That was the sum total of information that was transferred in exchange for the tuition paid. The diagnosis as I witnessed it consisted of a quick gliding pressure from the upper dorsal to the middle lumbar to detect the position of posterior apical prominences. That was the sum total of examination that was given to any patient. The treatment consisted of giving a single forceful lunge on that prominent apex, using the flat of the hand as a contact. That was the sum total of the treatment. Nothing else was done. The patient's treatment for that day was finished. These treatments were given daily. There were no charts made, no histories taken, and no records made. After being permitted to watch this identical form of treatment for six days I was told that I knew all that was necessary for me to know, and that I should do the treating myself thereafter.

It seems that early in the new century another student of Palmer's, whose name was Reiring, was also concerned about the quality of chiropractic education that he had received. He sought advice to get the \$500 that he had paid to Palmer returned (Lerner, circa 1952, p. 259). Legal action followed. This was a challenging period for Palmer. According to his son (Palmer, 1950, p. 60), following a phase of growth in his chiropractic practice in Davenport, business began to drop off and he fell into debt. This was also a time when medical licensing laws were being enforced in Iowa, so the threat of prosecution for illegal practice of medicine hung over him (Zarbuck & Hayes, 1990). In or about 1902, Daniel Palmer made a decision to leave Iowa, transferring his assets in Davenport to Bartlett Palmer in order to protect them. A key moment in chiropractic's early development was reached. The elder Palmer took his message of chiropractic beyond Iowa. He travelled to the west coast of the United States where he was involved in setting up a school in Portland, Oregon, called the Pacific College of Chiropractic (also known as the Portland College of Chiropractic). Daniel Palmer's departure from Davenport marked the beginning of Bartlett Palmer's move to the centre stage of chiropractic.

With his father temporarily away from Davenport, the younger Palmer faced his own challenges. Having only recently received a short education in chiropractic, and at about the age of twenty-one, he found himself in charge of his father's practice and school, which became known as the 'Palmer Infirmary and Chiropractic Institute' (Wardwell, 1992, p.59). Lerner (circa 1952, p. 274) tells us that in January 1903 Bartlett Palmer was indicted for violating the Medical Act in Iowa, although the case did not go to trial and was eventually withdrawn. Under the law, he could not legally practise chiropractic, but he could legally teach it, and he did. Carver (circa 1936, p. 45) has stated that Bartlett Palmer's uncle, Howard Nutting, came to Bartlett Palmer's financial rescue at this time. Without an external source of financial support it is hard to see how the practice and school in Davenport could have survived. As it turned out, during his father's absence, the school was given a new lease of life. A marketing campaign was initiated that included full page adverts in local papers. In 1905 the school moved to a new building in Davenport and had its first formal graduation. It is testament to the character and entrepreneurial skills of the younger Palmer that students were drawn to Davenport. There may have been as many as thirty students in 1905, seventy-five in 1906, and ninety-six in 1907 (The Chiropractor, 1911a). Education became more formalised, the course was lengthened, and a teaching faculty was established. In 1906 a course in chiropractic could be purchased from the school for \$100. This was much more affordable than the chiropractic apprenticeship offered by Daniel Palmer in 1897. In 1907 the school changed its name to the 'Palmer School and Infirmary of

Chiropractic'. In the years that followed it became affectionately known by its supporters as the 'Fountain Head' of chiropractic.

Whereas the term 'chiropractic' had first been applied to Daniel Palmer's practice, this did not stop others employing similar methods, calling themselves chiropractors, or purporting to teach chiropractic (Homola, 1963, pp. 101-102) . Keating, Callender and Cleveland (1998, p. 3) have noted that as early as 1899 the National School of Neuropathy and Psycho-Magnetic Healing based in Minneapolis, Minnesota, advertised that it taught "chiropractice" along with osteopathy, massage, Swedish movement, hypnotism, hydropathy, magnetism, hygiene, psychic sciences and mental sciences, all as part of its neuropathy course. Then, as now, it was not uncommon for healthcare practitioners to commit to more than one non-orthodox medical system, or to combine orthodox and non-orthodox practices, consequently blurring the boundaries between therapeutic disciplines (Cooter, 1988, p. xiv).

In 1903 Solon Langworthy, who had studied under Daniel Palmer, set up a school in Cedar Rapids, Iowa, in competition to the school in Davenport. Whilst accepting many of Daniel Palmer's ideas, Langworthy and his likeminded colleagues Oakley Smith and Minora Paxton (also both former students of Palmer), sought to incorporate the principles of Palmer's chiropractic within a wider context of 'nature cure', encouraging integration of chiropractic, osteopathic and other natural approaches. Daniel Palmer was critical of Langworthy (The Chiropractor, 1904b, p. 6):

Bro. L. [sic] it is not necessary to inform the public that you have mixed Chiropractic and Osteopathy; for your literature shows that you use an Osteopath table and a stretching machine. A Chiropractor has no use for either of the above appliances. You learned Chiropractic without adjuncts during the year of 1901, at The Palmer School of Chiropractic, at Davenport, Ia.

A division thus emerged between those who practised what the Palmers described as 'straight chiropractic', involving the detection of subluxations and their correction by hand, and those who 'mixed' this with other methods.

In spite of the small number of individuals who had trained under Daniel Palmer in the first years of his school, Palmer encouraged his earliest students both to practise and teach, and within a few years of completing their training a high proportion of them had set up their own schools. Carver (circa 1936, p. 32) informs us that:

By June of 1906 there were some six or seven Chiropractic schools and colleges scattered widely over the United States, and it was a very notable fact that while they were conducted by Dr. D. D. Palmer's graduates, each school had a different theory as to the art of Chiropractic, which it attempted to teach and demonstrate.

It seems that Palmer was less successful than he might have been in instilling his version of chiropractic into his students. In part this was probably because of the rather limited training that he offered at Davenport, but there were almost certainly other reasons. For one thing, at the time when the first students studied under Palmer his system of chiropractic was still in its developmental phase, and his ideas were not set in stone. For another, Palmer's first students came from a variety of backgrounds. A significant proportion of them were already healthcare practitioners, including a few who had studied medicine (Gibbons, 1981). It is not unreasonable to assume that some would have seen the study of chiropractic as adding another string to their therapeutic bow, rather than necessitating the rejection of methods that they had previously learned. In other words, one might argue, they were interested in elements of what Palmer had to teach, rather than the whole system of chiropractic.

Langworthy, Paxton and Smith initially described their practice in Cedar Rapids as "modernised chiropractic" (Smith, Langworthy & Paxton, 1906), but by 1908 Smith considered this description obsolete, and he chose instead to name his work "naprapathy" (Smith, 1932, p. 10), from the Czech 'napravit' (meaning 'to rectify'), and the Greek 'pathos' (meaning 'suffering'). He founded the Oakley Smith College of Naprapathy (which later became the Chicago College of Naprapathy). Another student of Daniel Palmer, Andrew P. Davis (not to be confused with Andrew J. Davis), who had also studied medicine and osteopathy, developed another derivative of chiropractic, naming his system (like that taught at the National School of Neuropathy and Psycho-Magnetic Healing) 'neuropathy' (Davis, 1915).

The years that followed saw a proliferation of chiropractic schools in the United States, and also other schools of a closely related nature. The distinction between the two was not always obvious. Some were set up by followers of Palmer, others were not. Whereas there can be little doubt that there were individuals who were quite genuine in their wish to spread what they considered to be a very important message about disease and its cure, chiropractic also caught the imagination of commercially-minded individuals more concerned with profits than quality of education or patient care. It was not long before chiropractic correspondence courses came into existence. The first was probably provided by the National School of Chiropractic in 1906, although Rehm (1992) informs us that it was

intended as a primer to more advanced residential study. The American University in Chicago, however, established in 1913, offered no such residential course, and advertised that any ordinary person could become a chiropractor in just a few months by mail (Creel, 1915). Whilst on-site instruction was the norm at the Palmer School of Chiropractic, for a short time even it advertised a home study course in chiropractic (Popular Mechanics, 1911 & 1912). It is not possible to know with certainty how many 'chiropractic' schools existed in the United States in the first quarter of the twentieth century, but research undertaken by Ferguson and Wiese (1988) points to there being more than sixty. Many different 'chiropractic' techniques were taught. Related therapies, such as Albert Abrams 'spondylotherapy', were promoted. From one perspective it might be concluded that there were more than a few illegitimate pretenders to Palmer's chiropractic, but from another it might be surmised that Palmer's chiropractic was simply one of a wider group of practices, no more legitimate than others.

Daniel Palmer had packaged a set of ideas and referred to them as chiropractic, but Bartlett Palmer stands out for his marketing and organisation of chiropractic. Not only was he in large part responsible for turning the Palmer School and Infirmary of Chiropractic into a successful long-term business venture, but he also acted as an organising influence for chiropractors in the field. The first association of those who called themselves chiropractors in the United States was probably the American Chiropractic Association that was linked to Langworthy's American School of Chiropractic and Nature Cure in Cedar Rapids. It, like the school, was short lived. The Universal Chiropractors' Association (UCA), on the other hand, set up in 1906 by Bartlett Palmer and other past-students of the Palmer School, was longer lasting and provided a key focus for occupational organisation. In the context of professionalisation, it provided an avenue for social closure, a means of differentiation between those deemed to be appropriately qualified by Bartlett Palmer and his colleagues, and those who were not. It was instrumental in helping to establish distinct identity. Its authority would come to extend beyond the boundaries of the United States and have a marked effect on the early development of chiropractic in Britain. Bartlett Palmer became the secretary of the new association and soon also its figurehead.

In the years following the formation of the UCA, Daniel Palmer continued to spread his message of chiropractic beyond Iowa. He was actively involved in the founding of the Palmer-Gregory College of Chiropractic in Oklahoma City in 1907, and the D.D. Palmer College of Chiropractic in Portland, Oregon in 1908. For his part, Bartlett Palmer focused his attention on developing chiropractic from Davenport. According to *The Chiropractor* (1911a), there were 505 students enrolled on the nine-month residential course at the Palmer

School of Chiropractic in 1910. The school was thriving, producing more graduates than any other chiropractic educational institution. Bartlett Palmer's charismatic leadership played a major part in its success. Stephenson (1927, p. ix) wrote that "...the Fountain Head of Chiropractic was B.J. and not the school."

With respect to the early development of the Palmer School, and notwithstanding the school's brief trial of a correspondence course, one might reasonably ask what had changed that required chiropractic training to be lengthened from what might have been as little as six days under Daniel Palmer, as described by Smith (1932, p. 6), to a nine-month course of study under Bartlett Palmer. What was included in the nine-month course at Davenport that had not been before, and why was it necessary to include this new material? Dye (1939, p. 224), a 1912 graduate of the Palmer School, tells us that in 1910 the course included lectures in anatomy; physiology; symptomatology, pathology and diagnosis; chiropractic philosophy; nerve tracing; palpation; spinal analysis; and clinical practice. There were also occasional lectures in toxicology and in obstetrics, and dissection of cadavers when they could be obtained (although it is not clear how these were obtained). From this it may be understood that students were given a stronger theoretical underpinning than previously; a more thorough grounding in basic and clinical sciences, and in the principles of chiropractic. By increasing the length of the course and the number of subjects included within the curriculum, the school was able, in theory at least, to present a more positive image of itself to strategic elites, to potential students, and to the public at large. In the marketplace the more extensive curriculum provided a basis for claiming educational superiority over competing schools, both chiropractic and non-chiropractic. Through their education students were immersed in the atmosphere of Palmerian chiropractic, and subject to the values and attitudes of their teachers, such that a process of 'socialisation' took place. Although Bartlett Palmer was opposed to medicalisation of chiropractic, it is striking that the curriculum at the Palmer School took on a form reminiscent of orthodox medical education, in part, one assumes, because this was an educational model associated with respectability. Be that as it may, the inclusion of pathology and diagnosis within the curriculum did not imply any fundamental change in thinking about the cause of disease. Bartlett Palmer was every bit as critical of germ theory as his father. As part of a commission into medical education in Ontario, Canada, he was reported as saying that chiropractors "did not believe in bacteria, and that bacteriology was the greatest of all gigantic farces ever invented for ignorance and incompetency" (Royal Commission on Medical Education in Ontario, 1918, p. 126).

In fact, medical education in the United States and Canada had been the subject of a previous detailed study by Flexner, one that would result in profound changes to medical

education. Reporting to the Carnegie Foundation in 1910, Flexner (1910, p. 158) was highly critical of chiropractic, which he did not consider to have a legitimate place within the medical sphere. He claimed that chiropractors were “unconscionable quacks” whose advertisements were “tissues of exaggeration, pretense, and misrepresentation of the most unqualifiedly mercenary character”. He considered that the public prosecutor and the grand jury were the agencies best suited to dealing with them. Although Flexner was also critical of osteopathy, he did draw an important distinction between it and chiropractic, for he considered osteopathy to be a dissenting part of medicine, rather than a separate, illegitimate entity. In the United States chiropractors and osteopaths were set to take divergent paths (Baer, 1987b). Whereas ties between osteopathy and the medical profession were to become stronger, the relationship between chiropractic and the medical profession was to be a turbulent one.

In the first decades of the twentieth century the threat of prosecution hung over those who practised chiropractic without also being registered medical doctors. Having escaped Reiring’s legal action a few years earlier, Daniel Palmer was found guilty of practising medicine without a licence in 1906 (The Chiropractor, 1906a). He refused to pay a fine, and was jailed. Palmer was one of many chiropractors to be convicted for illegally practising medicine (Kimbrough, 1998). Some of his contemporaries suffered multiple convictions. Palmer placed the blame for the ruling in his case squarely in the camp of the medical profession. He stated (The Chiropractor, 1906a, p. 37):

The jury was not to blame for rendering the verdict they did. Behind the jury was the judge, who gave his instructions. Behind the judge was the medical law. This law was not made by the people, but by the medical profession. It was made for the purpose of protecting that profession.

With respect to the protection of their jurisdiction, it was in the interest of the medical profession to ensure that ‘outsiders’ were not permitted to intrude upon what medical doctors deemed to be their domain (Abbott, 1988, p. 138). In this the law was on their side. In order to successfully defend themselves in the courts, chiropractors would have to convince juries that chiropractic was distinct and separate from medical orthodoxy. This was exactly what they attempted to do. Chiropractors emphasised their difference from the medical profession, arguing that they held contrasting beliefs, used distinctive language, and practised in a dissimilar way to medical doctors. It was claimed that the word ‘subluxation’ had a unique meaning to them. Chiropractors made ‘adjustments’ to the spine, rather than ‘manipulations’. They emphasised the role of the nervous system in the understanding of disease.

The first successful legal defence of chiropractic came in 1907 when Shegataro Morikubo was acquitted by a court in Wisconsin, having been charged with practising medicine, surgery and osteopathy without a licence. Other successful legal defences followed. In the interests of defending chiropractic in the courts, Daniel Palmer went as far as to suggest that chiropractic might be defined as a religion (Palmer, 1911 & 1914, pp. 1-12), citing the Constitution of the United States that “Congress shall make no law respecting an established religion or prohibiting the free exercise thereof.” As it turned out, it never came to this. Daniel Palmer died in 1913. The defensive actions of chiropractors encouraged intra-occupational organisation and increased solidarity between practitioners. They were instrumental in advancing occupational unity.

3.3 Conclusions

The history presented within this chapter is relevant to the thesis at hand not so much because of what it tells us about the origins and early development of chiropractic in the United States, but because of what it tells us about the origins and development of chiropractic *per se*, and because of the way in which it informs discussions about the history and professionalisation of chiropractic in Britain. There are a number of key messages from this chapter that are highly relevant to the thesis.

In light of the foregoing discussions, it must be recognised that chiropractic had complex origins. It is misleading to state simply that it was ‘discovered’ by Daniel David Palmer. Although the term ‘chiropractic’ was first applied to his practice, Daniel Palmer did not have a monopoly over its use, and others, some with quite different perspectives to Palmer, chose to describe themselves as chiropractors. Chiropractic was but one of a number of similar practices that existed in North America in the late nineteenth and early twentieth centuries; others being osteopathy, naturopathy, neuropathy and spondylotherapy.

Even so, Daniel Palmer and his son Bartlett Palmer effectively packaged and marketed their particular mechanotherapy and, in doing so, helped to lay the foundations for its subsequent professional development. The charismatic leadership of Bartlett Palmer attracted students to chiropractic and through their training and socialisation central foundations were laid for the future evolution of chiropractic not only in the United States, but also in Britain. With respect to the sociology of professions, it is notable that the Palmers developed a focus of occupational interest; they made a full-time commitment to that focus and promoted it; they set up schools and an association; they established authority recognised both by their clientele and by their colleagues; and they defended job territory.

Essential to the discussions that will follow is the idea that Daniel Palmer's chiropractic was not intended to be an adjunct to medical orthodoxy. Instead, it was intended to be an alternative and exclusive system of healthcare. Palmer's philosophy of chiropractic involved the superimposition of vitalistic principles upon naturalistic principles. At a time when scientific medicine was in its ascendancy, Palmer advocated scientifically unverifiable and unfalsifiable claims to truth. The combination of vitalism and naturalism in Palmer's thought provided chiropractic with a mixed legacy, a source of complexity and ambiguity. It would lead to intra- and extra-occupational tensions and deep controversies. Fundamentally, chiropractic's 'religious' aspect was at odds with the prospect of its professionalisation in healthcare environments dominated by the medical profession.

CHAPTER 4

The Origins of Chiropractic in Britain

It is perhaps tempting to view chiropractic in Britain in its earliest form simply as an import from the United States. Chance (1997) has described how chiropractic was ‘exported’ to the world following Daniel David Palmer’s ‘discovery’. The reality was more complex, for in Britain as in North America there existed individuals who practised manipulative therapies before there existed those who first designated themselves as chiropractors. Additionally, even after the ‘arrival’ in Britain of the first chiropractors who had studied in the United States, there were others who called themselves chiropractors who had not undertaken such an education. Anyone could call themselves a chiropractor without breaking the law. The result was a diversity of approach and background that made precise definition of chiropractic impossible.

In this chapter the forebears and origins of chiropractic in Britain are investigated. The chapter begins by exploring the context in which chiropractic was to appear, providing essential historical background for subsequent discussions. The longstanding tradition of manipulative therapy within medicine and the presence of bonesetters in Britain prior to chiropractic are considered, as is the professionalisation of medicine during the nineteenth century and its effect on unorthodox healthcare practices. Following an examination of the demise of bonesetting and the colonisation of its territory by medical manipulators, the focus moves to the appearance of two ‘new’ unorthodox groups of manipulative practitioners in Britain – osteopaths and the chiropractors. The question of why chiropractic gained a foothold in Britain is considered.

4.1 Chiropractic in Britain: its historical context and antecedents

In chapter 3 attention was given to the antecedents of Daniel David Palmer’s chiropractic, to the ideas and practices that would seem to have informed Palmer’s system of beliefs, whether wittingly or unwittingly. It is notable that amongst the possible influences on Palmer were writings from Britain, those of medical doctors such as Harrison and Brown on the subjects of subluxation and spinal irritation. It is also notable that spiritualism, which influenced the development of Palmer’s chiropractic metaphysics, found a place for itself within British society during the Victorian era (Howitt, 1863, pp. 214-234; Nelson, 1969, pp.

89-110). As regards the practice of manipulation, before there were those who called themselves chiropractors and osteopaths in Britain, there were medical doctors and bonesetters who adjusted what they supposed to be structural and functional faults within the body using their hands.

It is not known when manipulation was first practised in Britain, however, one might suppose, rightly or wrongly, that its beginnings predate the time of formal written records, and one might go so far as to suspect that even within the earliest of social orders dislocated, stiff and painful joints were pulled and twisted with a view to restoring normal joint relations, improving function and providing symptomatic relief. It is known that from the time of Hippocrates manipulation found a place within the western medical tradition and that manipulations were performed by medical doctors (Schiötz & Cyriax, 1975, pp. 5-14), however it is not clear whether the Greeks used manipulation merely to correct gross skeletal distortions, fractures and complete dislocations, or whether they also treated more minor bony displacements and dysfunctions, later to be called ‘subluxations’ (Lomax, 1975, p. 11; Lomax, 1977, p. 207).

During the Renaissance, following the development of the printing press, Friar Moulton’s book *The Compleat Bone-setter* (1656), published in London, attempted to bring techniques of manipulation, and also other mechanisms for the improvement of physical conditions, to the attention not only of the learned, but also to the unlearned and to the poor, so that they might “come to be their own Physicians in time of need” (p. 2). Moulton’s book concentrated predominantly on the treatment and management of broken bones, dislocations and hernias. He advised upon their reduction, and also upon the preparation and use of such things as drinks, enemas, ointments, plasters and poultices. Whilst recognising the existence of more minor joint displacements (p. 20), he paid relatively little attention to them in his book, instead choosing to focus primarily on more serious maladies, physical injuries and disorders that by their nature had the potential to severely debilitate, maim, or even threaten life.

Although *The Compleat Bone-setter* could not have directly informed the illiterate, a folk tradition of bonesetting did evolve in Britain in the centuries before word of ‘chiropractic’ reached this country (Schiötz & Cyriax, 1975, pp. 28-37; Leyson, 2004, pp. 239-242). Necessary knowledge and skills were passed on orally, often within families, rather than through processes of formal education.

Most of those who practised bonesetting were neither wealthy, nor well known, but a few individuals did rise to become celebrated. In the 1730s, for example, Sarah Mapp was the subject of the following verses produced for a play, as reported in the *Gentleman's Magazine* (1736, p. 618):

You surgeons of London, who puzzle your pates, to ride in your coaches and purchase estates, give over, for shame, for your pride has a fall, and the doctress of Epsom has outdone you all.

What signifies learning and going to school, when a woman can do, without reason or rule, what puts you to nonplus, and baffles your art; for petticoat practice has now got the start.

Dame nature has giv'n her a doctor's degree, she gets all the patients and pockets the fee; so if you don't instantly prove her a cheat, she'll loll in her chariot whilst you walk the street.

Sarah Mapp was depicted by Hogarth as cross-eyed, stout and unattractive (Trusler, 1833, pp. 59-60 and preceding plate). More importantly, she was female. 'Regular' medical doctors of the eighteenth century were, almost without exception (see Porter, 2000, pp. 84-86), male. The fact that bonesetting was sometimes practised by women had negative implications for the perception of its status within British society.

By the eighteenth century the use of manipulation had become strongly associated with folk practitioners and it would appear that it was used less often by 'regular' medical doctors (Anderson, 1983; Pettman, 2007). Whilst the association between manipulation and those of low social status might have reduced the appeal of manipulative practice to regular doctors, there may have been other reasons for its fall from favour. For during the eighteenth century awareness of the dangers inherent in the manipulation of patients suffering from tuberculosis increased (Lomax, 1975, p. 12; Lomax, 1977, p. 208). Where bones were weakened by the disease, the application of forceful thrusts to joints could do more harm than good. Further, although germ theory was yet to be proposed, there was an awareness in the eighteenth century of the possibility of contagion, and it is not unreasonable to assume that the physical contact required of manual therapy might have caused concern (Anderson, 1983). For these, or other reasons, during the eighteenth century it was bonesetters, rather than regular medical doctors, who were primarily responsible for maintaining the tradition of manipulation in Britain. As medicine professionalised, and as the boundary between 'folk' and 'orthodox' medicine became more rigid, the practice of manipulation came to be situated predominantly on the 'folk' side of the divide.

As this discussion illustrates, it is difficult to separate the history of bonesetting, and the history of manipulation, from the history of medicine more generally. In light of this, attention is now turned to the professionalisation of medicine itself.

Between the late eighteenth century and the early twentieth century medicine professionalised and the healthcare environment in Britain was transformed, with significant repercussions for those who practised in an unorthodox fashion. Prior to the *Medical Act* of 1858 (Act of Parliament, 1858), medical doctors recognised under English law (the law being somewhat different in Scotland) were formally divided into three groups (Waddington, 1984, pp. 1-8; Jacyna, 2006, pp. 29-31). Firstly, there were physicians, who diagnosed and prescribed remedies. They were governed by the Royal College of Physicians, and were characterised as gentlemen, the most prestigious of medical doctors. Secondly, there were surgeons, whose work was generally more manual than that of physicians. Surgeons practised surgery, but they were not confined only to surgery, and the scope of practice of the typical surgeon often included such things as blood letting, and the management of wounds, fractures and dislocations. Surgeons were governed by the Royal College of Surgeons. Thirdly, there were apothecaries, responsible for preparing and dispensing medications, whose work was closely associated with that of physicians. Although apothecaries held the legal right to prescribe medications themselves, which they did, they also frequently acted in accordance with the requests of physicians. Indeed, under the *Apothecaries Act* of 1815 (Act of Parliament, 1815) it became a legal offence for an apothecary to refuse to prepare, or deliberately incorrectly prepare, the prescription of a physician. Apothecaries were subject to the authority of the Worshipful Society of Apothecaries.

This tripartite classification of medical doctors, although accurate from a legal perspective, was less than accurate in respect to the everyday practice of clinical medicine. As a matter of fact, before the nineteenth century an additional class of medical practitioner, the surgeon-apothecary had begun a rise to prominence. In 1783 Simmons produced a register of provincial medical practitioners in England (Simmons, 1783; Lane, 1984). According to his register the majority of medical practitioners practising outside the capital were not apothecaries, physicians or surgeons, but surgeon-apothecaries, a class of doctor later to become known as 'general practitioners' (Loudon, 1986, p. 1).

Whilst Simmons focused attention on the 'regulars' within medicine, it is important to recognise that there were also a good many other healthcare workers vying for trade in 1783. There were nurses who attended the sick, and midwives who assisted in childbirth. As

previously described, there were bonesetters, and also other folk healers, who provided for those unable to afford the services of the regular doctors. Then there were those who, as Porter (2000, p. 204) put it, “clung to the regulars’ coat-tails and bathed in their reflected glories”, individuals sometimes referred to as ‘quack doctors’. In the field, regulars and irregulars often worked side by side in a climate of tolerant multiplicity, or medical pluralism (Harris, 2004, p. 92). Although there was competition between practitioners, by and large the irregulars did not wish to be seen as being wholly separate from the regulars. In fact, during the eighteenth century any distinction to be made between regular and irregular medicine, between orthodox and unorthodox medicine, must necessarily be subjective, for in the absence of standardised medical education and of a legally binding single register of medical doctors, no clear-cut division existed between *bona fide* doctors and pretenders to the name (Loudon, 1986, p. 13). There was no litmus test to distinguish “pukka doctors” from quacks (Porter, 2000, p. 20).

By the early nineteenth century this situation had changed. Increasingly, formalised medical education distinguished certain groups of medical doctors from others. Claims to status within medicine based upon family background and the lifestyle of a ‘gentleman’ were replaced by a new-found respect for qualifications, medical knowledge and clinical expertise. As science came to be increasingly valued within society, it also came to underpin medicine in a way that it had not done previously. By associating themselves with science, regular medical doctors helped to advance their position in professional terms and distinguish themselves from their competitors (Bynum, 1994, p. 118). In reaction, there rose to prominence conspicuous groups of practitioners, and also individuals, who were philosophically opposed to the practices of the regulars. As in the United States, homeopaths, Thomsonians and eclectics made their presence felt. One notable individual campaigner was James Morison. He warned the public that the theories of regular doctors were wrong and that their practices were dangerous (Porter, 2000, pp. 200-203). He believed that disease was caused by impure blood and that purging the blood of contaminants was the only effective cure for disease. For this he recommended Morison’s Universal Pills, a vegetable based laxative available in two strengths.

During the first half of the nineteenth century competition between healthcare practitioners was intense and pressure mounted for a reform law to prevent the ‘unqualified practice’ of medicine (Loudon, 1986, pp. 208-210). Furthermore, surgeon-apothecaries called for adequate political recognition and representation of their practice, satisfactory provision for education and examination in general practice, and formal registration of general practitioners (Waddington, 1984, p. 94).

Proponents of medical reform organised themselves and lobbied for the introduction of statutory regulation to protect their interests and those of their patients. Political agitation ultimately resulted in the *Medical Act* of 1858 (Act of Parliament, 1858). The Act required the establishment of a single register of legally recognised medical practitioners, under the authority of a new General Council of Medical Education and Registration of the United Kingdom, later known more succinctly as the General Medical Council (GMC). Physicians, surgeons, apothecaries and general practitioners were listed equally, accepted as medical practitioners under law. Other healthcare practitioners were excluded. It should be stated that the Act did not go as far as some reformers would have wished. A restrictive clause in the original Bill that would have made it possible for doctors to be struck off for practising unconventional therapies was removed before the passing of the Act. The *British Journal of Homeopathy* (1858, p. 534) reported that:

...all the fangs of this serpent that threatened death and destruction to homeopathy have been effectively drawn, and no ingenuity can pervert the Act into an instrument for our suppression or annoyance.

Nonetheless, a partition had been erected between the recognised and the unrecognised. Occupational closure had been achieved and with it a competition-orientated advantage had been granted to the registered. It became an offence to falsely pretend to be registered under the Act. Public appointments became the sole domain of the registered. State approval was conferred upon those who successfully registered and denied to those who could not, or did not register. Registered medical practitioners were permitted to practise unconventional therapies themselves, but under the provision of the Act a doctor could be removed from the register for sending a patient to an unregistered practitioner. Unregistered practitioners continued to practise legally under common law and continued to pose a competitive challenge, but from this point on they were separated from the medical mainstream.

The *Medical Act* of 1858, although fundamental to the professionalisation of medicine in Britain, did not mark the end of the process of medical reform. The Act of 1858 did not require medical students be examined in all branches of medicine, and it did not specifically provide for representation of general practitioners on the General Medical Council. In effect, it constituted a compromise between the wishes of reformers and those of conservatives. The *Medical Act* of 1886 (Act of Parliament, 1886), however, went further. It required all prospective medical doctors to be examined in general medicine, surgery and midwifery, and it increased the representativeness of the Council by requiring that five persons be elected to the Council by means of a postal vote of registrants.

As a result of medical reforms that took place during the nineteenth century, the social distance between bonesetters and medical doctors widened. By the time that those who first called themselves chiropractors began to practise chiropractic in Britain early in the twentieth century, the medical profession had attained a position of dominance within British healthcare. Rather than being included within a landscape of medical pluralism, as they might have been if they had practised in the late eighteenth century, chiropractors would find themselves outside the medical fold, legally disadvantaged with respect to the profession of medicine.

Even prior to the processes of professionalisation of medicine that took place during the nineteenth century, bonesetters and medical doctors were not natural bedfellows. In the years before the *Medical Act* of 1858 clinical interactions between medical doctors and bonesetters were permissible and did occur; however, after 1858, a medical doctor who referred a patient to a bonesetter, delegated care to a bonesetter, or worked with a bonesetter, ran the risk of being removed from the medical register. The surgeon Dacre Fox (1882, p. 843) wrote of bonesetting that it was “almost exclusively employed by a class of persons who are without our pale”. From a medical perspective, bonesetting had a stigma about it, and use of manipulation was coloured by its association with bonesetting.

That said, after the *Medical Act* of 1858 there were bonesetters who through their endeavours, contacts and merits, came to be respected by some members of the medical profession. Prominent British bonesetters of the nineteenth century included Richard Hutton and George Bennett. Arguably, however, the bonesetter who was most well-known in his lifetime and who ultimately achieved the greatest admiration from within the medical profession was Herbert Barker (Schiötz & Cyriax, 1975, pp. 34-37; Bishop, 2002). In view of this, it is striking that in 1911 Barker was found guilty of negligence in respect to the care of a patient (British Medical Journal, 1911a) and that following the case Frederick Axham was struck off the medical register for acting as his anaesthetist (British Medical Journal, 1911b). Nevertheless, in 1920 more than 300 MPs signed a petition to the Archbishop of Canterbury calling for him to be awarded an honorary ‘Lambeth degree’ in medicine in recognition of his services to patients during World War I. Although he was not awarded the degree, not long afterwards Sir Henry Morris (ex-President of the Royal College of Surgeons of England), Sir Alfred Fripp (Surgeon Ordinary to the King), Sir Arbuthnot Lane (consulting surgeon to Guy’s Hospital), and Sir Bruce Bruce-Porter (an eminent physician of the day), wrote to the Prime Minister David Lloyd George requesting that a means be found of marking the public’s appreciation of Barker’s work (Barker, 1927, pp. 240-241). Barker was knighted in 1922 (The Times, 1922a). Barker’s renown, and the conferring of a

knighthood upon him, almost certainly reflected for the most part Barker's social contacts and recognition of his individual skills, rather than the fact of his being a bonesetter. In announcing his knighthood, neither the *London Gazette* (1922), nor *The Times* (1922a & 1922b), described him as a bonesetter, but instead as a specialist in 'manipulative surgery'.

Notwithstanding the social distance that existed between medical doctors and bonesetters following the *Medical Act* of 1858, it is appropriate to highlight that in the second half of the nineteenth century there were those within the British medical fraternity who not only thought positively of some of the work that bonesetters did, but who also actively encouraged medical doctors to 'colonise' (or re-colonise) the territory of bonesetters. One such person was James Paget (1867) who lectured on the "cases that bonesetters cure", and who encouraged his medical colleagues to learn from bonesetting. Wharton Hood (1871a, 1871b, 1871c & 1871d) was another. He wrote a series of articles about bonesetting for the *Lancet*, afterwards publishing the material in the form of a book (1871e).

The nature of bonesetting was such that the precise number of individuals who claimed to be bonesetters during the nineteenth century cannot be known. There were no national registers of practitioners kept, and bonesetters did not organise themselves into associations of any significance. They wrote little down. Even so, a sense that they were numerous can be gleaned from a comment made by Paget in 1867 (p. 1), for in presenting to his colleagues on the subject of bonesetting, he stated: "few of you are likely to practise without having a bone-setter for an enemy". An impression of the work that bonesetters did during the nineteenth century can also be gathered from Paget. According to Paget, bonesetters reduced fractures, dislocations and dislodged tendons; they managed internal derangements of joints, and joints that were stiff or sprained; and they treated by means of "wrenching", and by other movements, through which they "put in" what was considered to have been "put out". Paget was not entirely complimentary about the manipulations of bonesetters, and crucially he believed that bonesetters lacked competence in diagnosis, meaning that they could be a danger to patients. Therefore, he reasoned, manipulation was best practised by medical doctors, rather than bonesetters. Hood (1871a, 1871b, 1871c & 1871d) was generally more flattering of bonesetting and presented through his observations of Richard Hutton the image of a practitioner who was highly skilled and precise in his techniques. The conditions that Hood saw treated by Hutton were generally consistent with those described by Paget.

Bonesetting, it would seem, shared in common with Daniel Palmer's chiropractic a focus on assessing joint positions, and a treatment approach that involved the use of manual thrust techniques with the aim of restoring normal joint relations. Bonesetting, like chiropractic,

carried with it an air of mysticism, for there was the understanding that only certain individuals were gifted with the knack (Romer, 1915, p. xi). On the other hand, bonesetting was not promoted as a panacea in the way that Palmer's chiropractic was, and it was not grounded in a *Weltanschauung* (world-view) that incorporated the belief in a spiritual intelligence that worked through the nervous system to maintain health.

The folk art of bonesetting did not thrive in the twentieth century. In the first decade of the new century it continued to be practised in various parts of the country, for example within the mining communities of Cumberland, Durham, Lancashire, Northumberland, and in parts of Wales (Parliamentary Papers, 1910, p. 8). In Scotland bonesetters were still consulted in hamlets and farms (Parliamentary Papers, 1910, p. 54). Even so, bonesetting was a surviving tradition from previous times, a practice under threat. In examining literature pertaining to the history of bonesetting, no detailed study of its decline has come to light. There can be little doubt that the professionalisation of medicine had a significant effect on the practice of bonesetting, however it seems likely that the origins of bonesetting's decline may also be linked to the processes of industrialisation that took place in Britain during the eighteenth and nineteenth centuries. During this time the settled life of communities in Britain, the patterns of living that had existed for many generations, were altered. It was a period when folk memories were lost as oral traditions discontinued. Although bonesetting survived into the industrial era, finding a niche within mining communities where injuries were common, as state sanctioned healthcare provision became more accessible, for example as a result of health insurance measures introduced by the Liberal government in 1911 (Harris, 2004, pp. 162-163), and as healthcare expectations changed within society, it would seem that the demand for bonesetters was reduced.

Bonesetting was not endorsed by the state. Lacking in formal organisational networks and educational structures, bonesetters were disadvantaged with respect to osteopathy and chiropractic as they developed. In contrast to osteopathy and chiropractic, bonesetting did not undergo a process of professionalisation of any significance (Leyson, 2004, p. 242-243). Viewed from a 'Darwinian' standpoint, it might be surmised that bonesetting did not adapt sufficiently to the changed environment in which it found itself.

It would be a mistake to assume that British bonesetting disappeared completely during the twentieth century – it didn't – however, as the number of those who called themselves bonesetters gradually dwindled, the art of bonesetting passed quietly into obscurity. As it happened, the practice of manipulation that had been employed by bonesetters was continued by others, including osteopaths and chiropractors. Ultimately, those bonesetters

who failed to embrace the new approaches found themselves sidelined by changes in the healthcare environment.

Following the events surrounding Barker in 1911, a series of articles about bonesetting appeared in the *British Medical Journal* that encouraged, rather than discouraged, use of manipulation by members of the medical profession (Marsh, 1911; Romer & Creasy, 1911a; Romer & Creasy, 1911b). In or about 1916, James Mennell began to teach manipulation to students of massage at St. Thomas' Hospital in London (Schiötz & Cyriax, 1975, p. 158), where he was assisted by Edgar Cyriax (Pettman, 2007). The significance of this should not be underestimated, for this was a time when massage therapists were working towards the attainment of increased respectability within British Society. In 1894 the *British Medical Journal* had linked massage with prostitution (British Medical Journal, 1894; Nicholls & Cheek, 2006). In response to the scandal that had ensued, two masseuses, Rosalind Paget and Lucy Robinson, had considered ways in which the practice of massage could be made safe, clean and honourable (Barclay, 1994, p. 23). Having pooled their ideas with those of others, efforts were made to found an association of massage therapists. The Society of Trained Masseuses was formed. In 1920 the Society of Trained Masseuses became the Chartered Society of Massage and Remedial Gymnastics, when it was amalgamated under Royal Charter with the Institute of Massage and Remedial Gymnastics (Barclay, 1994, p. 70). In 1944 this organisation became the Chartered Society of Physiotherapy. Mennell and Cyriax were amongst those responsible for first introducing manipulation to those who would become 'physiotherapists'.

Both James Mennell's son, John Mennell, and Edgar Cyriax's son, James Cyriax, studied at St. Thomas' Hospital. Both became medical practitioners and teachers of manipulative therapy, or 'manipulative surgery', as it was often referred. Whereas John Mennell went to work in the United States, James Cyriax taught manipulation to students at St. Thomas' from 1938 (Schiötz & Cyriax, 1975, p. 175). He continued at St. Thomas' until his retirement in 1969 (Robson, 1985). In the cases of both Mennell and Cyriax the practice of manipulation passed from father to son, as it had within families of bonesetters. In contrast, however, not only did James Cyriax and John Mennell learn about manipulation in the formal setting of the teaching hospital, but the 'mystique' associated with bonesetting was essentially absent from manipulative medicine. Within the confines of medical orthodoxy, the technical ability to assess and treat patients effectively using manual therapy was not seen as a "mysterious gift" that might be passed to one's children (Romer, 1915, p. xi). Instead, 'orthopaedic manipulative therapy' had a propensity to be practical and down to earth. The nature of scientific medicine was such that in general a dim view was taken of ideas that appeared to

be superstitious or mythological as they related to patient care. On the whole, medical books on manual therapy, such as Romer's *Modern Bonesetting for the Medical Profession* (1915), and Fisher's *Treatment by Manipulation* (1928), did not discuss the supernatural in the context of good clinical practice. In this respect the style of orthodox medical books on manipulation tended to be different from early texts on chiropractic and osteopathy. Andrew Taylor Still had described osteopathy as "God's law" (Still, 1897, p. 275), and Daniel David Palmer had proclaimed that inherent to the practice of chiropractic was "a religious duty" (Palmer, 1914, p. 2). There was a religious, or quasi-religious quality to some early chiropractic and osteopathic writings that distinguished them from writings about manipulative medicine.

Prior to World War II, medical manipulators embodied the face of manipulation within state-sanctioned British healthcare. Almost without exception, they were individuals who had been formally educated, socialised into the medical scientific paradigm, and who saw manipulation as having a limited scope in the struggle against disease. Masseuse manipulators, the forerunners of physiotherapists, were by and large their associates and allies, sanctioned through Royal Charter from 1920 onwards. Osteopaths, chiropractors and bonesetters (those that remained), on the other hand, represented the face of heterodoxy within British manual therapy.

4.2 The beginnings of chiropractic and osteopathy in Britain

The general demise of traditional bonesetting in Britain and the resurgence of interest in manipulative medicine during the late nineteenth and early twentieth centuries provide a context in which to consider the beginnings of chiropractic and osteopathy in Britain. Neither chiropractic nor osteopathy in Britain should be considered wholly products of the United States, for each had forebears in this country. On the other hand, it must be recognised that the actions of Daniel David Palmer and of Andrew Taylor Still in the United States were essential to the genesis of chiropractic and of osteopathy, and essential to their origins in Britain. Chiropractic and osteopathy did not simply 'emerge' from the canvas of pre-existing British healthcare. Neither were they simply 'introduced' onto it. Instead, as they developed, they became the product of a complex combination of the two.

According to McKeon (1938, p. 31) and Collins (2005, pp. 11-12), word of 'osteopathy' was brought to the British Isles in 1898 by John Martin Littlejohn, a follower of Still. Littlejohn lectured on osteopathy in London, before returning to the United States. Not long afterwards other followers of Still set up practices in this country. A problem for the first osteopaths

working in Britain was that unlike medicine, but not unlike massage, osteopathy was not subject to specific regulation under law and anyone could legally call themselves an osteopath. Osteopathy was not legislated for, and was not a part of the prevailing medical orthodoxy. Publication of a *Home Study Course in Osteopathy, Massage and Manual Therapeutics* (Psychic Research Company, 1904) soon after word of osteopathy had reached Britain meant that any person could study 'osteopathy' from home. The consumer had no easy way of distinguishing the competent practitioner from the incompetent practitioner.

By 1910, however, those practising in Britain who had studied osteopathy in the United States were sufficient in will and number to form an association, setting themselves apart from others who chose to describe themselves as osteopaths. Initially called the British Osteopathic Society, their organisation was soon renamed the British Osteopathic Association (BOA). It was set up with the intention of providing a list of 'recognised osteopaths' (essentially a list of North American trained osteopaths), and also to advance osteopathy, uphold ethical standards, and encourage a 'professional' spirit (Collins, 2005, p. 14). Perceiving the need for formal osteopathic education in Britain, Littlejohn, who had been teaching osteopathy in the United States, began to work with others towards the founding of a British school. Their efforts led to the incorporation of the British School of Osteopathy (BSO) in London in 1917.

Probably 'chiropractic' was first heard of in Europe some time after osteopathy. In an article entitled 'The first European chiropractors' (Wilson & Wilson, 2007) the beginnings of chiropractic in Europe were examined. Whilst records suggest that the first osteopathic pioneer arrived in Europe before the end of the nineteenth century, the earliest available evidence linking chiropractic to Europe is correspondence from Elizabeth Van Raders, of Nice, France, to Daniel Palmer, dated 28th March 1905 (Van Raders, 1905). Van Raders tells us that she came across chiropractic when she saw an advert for the Palmer School in *Medical Talk* (Van Raders, 1906), a periodical published in Columbus, Ohio. She sent off for literature about the school, subscribed to its journal *The Chiropractor*, and subsequently travelled to study chiropractic in Davenport.

It is not known precisely when word of chiropractic first reached Britain. There is reason to believe that Godfrey Heathcote was probably the first British national to study chiropractic at the Palmer School of Chiropractic. His photograph appeared as part of a class group in an issue of *The Chiropractor* published in 1906 (The Chiropractor, 1906b), and also in the book *The Science of Chiropractic* (Palmer & Palmer, 1906, illustration no. 25, to be found subsequent to p. 100). It is noteworthy that Heathcote did not travel from Britain to study

chiropractic, for he was already in the United States when he first heard of chiropractic and made the decision to go to Davenport (Heathcote, 1906). What is more, evidence suggests that having studied chiropractic Heathcote did not immediately establish a practice in Britain. In 1908 “G.P.M. Heathcote, DC” (Doctor of Chiropractic) was listed as a member of the Universal Chiropractors’ Association in Los Angeles, California (The Chiropractor, 1908).

Although Heathcote was in all probability the first British person to study chiropractic at the Palmer School, it is appropriate to recognise that by 1906 the Palmer School was but one educational institution in the United States that made the claim to train chiropractors (see pp. 50-52). Langworthy’s American School of Chiropractic and Nature Cure had been in existence in Cedar Rapids since 1903, and at least half a dozen other ‘chiropractic’ schools had come into existence between 1904 and 1906 (Carver, circa 1936, p. 32; Keating, Cleveland & Menke, 2004, p. 15). Records from the period are incomplete, and therefore it is not possible to establish with absolute certainty that Heathcote was the first British citizen to undertake formal study of chiropractic.

The first person to travel from Britain to study at the Palmer School of Chiropractic was probably Arthur Eteson, who left Liverpool in October 1907 and became a student of chiropractic in November of that year (Eteson, 1908a). The *Davenport Democrat and Leader* recorded that (The Chiropractor, 1907):

Chiropractic’s Fountain Head, 828 Brady Street, Davenport, lays claim to the distinction of being the only school of its kind in America to which an English citizen has especially journeyed to study. The gentleman who has come to Davenport for that purpose is Arthur D. Eteson of Southport, England, who for many years has studied and practiced various reformed and rational methods of healing, in the old country.

The reference to Eteson’s previous practice is intriguing, and one wonders whether he might have practised as a manipulator before travelling to the United States to be trained as a chiropractor. If so, there is the question of how his practice changed following his chiropractic training. Unfortunately additional information about his prior work was not available. What is clear is that Eteson returned to England soon after his chiropractic education. In a letter to Bartlett Palmer, sent from Southport in 1908, he stated that he had received, and that he had been using, an adjusting table (Eteson, 1908b). In another letter to Bartlett Palmer he reported that he was using chiropractic methods in England (Eteson, 1910). On the basis of available evidence, it therefore seems likely that Eteson was the first

to set up a chiropractic practice in Britain. More important to this thesis, however, is the fact that Eteson's case provides evidence in support of the contention that from 1908, or there about, Palmer-based chiropractic was practised in Britain.

Osteopaths and chiropractors working in Britain in the first decades of the twentieth century shared in common with one another unconventionality and lack of state sanction.

Accordingly they stood apart from medical manipulators, and also from the masseuse manipulators who worked alongside medical doctors; however, the distinction between osteopath and chiropractor was not clear-cut. Neither, for that matter, was the distinction between osteopath, chiropractor and bonesetter. As a consequence of common law, in Britain anyone could call himself or herself a bonesetter, a chiropractor, or an osteopath. It did not matter whether one had undertaken relevant formal residential study; whether one had engaged in a correspondence course; whether one had worked as an apprentice, or embarked upon self-directed study; or whether one had had no relevant education or training at all. All were essentially equal under law. In 1926 Henry Jones (pp. 9-10) wrote of the 'new wave' of unorthodox manual therapists:

In England these new practitioners frequently work as isolated units; in America they are very powerfully organised, and have received official recognition. In England they often call themselves manipulators, bone-setters, or by similar name, though latterly the words "chiropractor" and "osteopath" have been increasingly used.

Although Henry Jones considered himself a chiropractor, and the chapters of his book focused predominantly on what he called 'chiropractic', it is significant that he chose to give his book the title *Healing by Manipulation (Bone-Setting)*. In Britain, in the first part of the twentieth century, in the absence of legal definition, any distinction to be made between bonesetter, chiropractor and osteopath was open to interpretation.

That is not to say, however, that all practitioners of bonesetting, chiropractic and osteopathy saw their occupations as being in essence one and the same. After all, bonesetting, chiropractic and osteopathy claimed to derive from different traditions. Bonesetters were the long established folk manipulators of fractures, dislocations, and other displacements within the body. Convention had it that they learnt their skills through apprenticeship.

Chiropractors and osteopaths, on the other hand, were the 'new' unorthodox manipulators. In general they promoted a vision of manipulative therapy that encouraged a broad scope of clinical practice, and encompassed the treatment of both organic and musculoskeletal conditions.

Osteopaths and chiropractors emphasised the role of manipulatable lesions in the causation of disease. They focused particular attention on the bones and articulations of the spinal column. In their origins, both osteopathy and chiropractic had links to the American Midwest. Both Still's osteopathy and Palmer's chiropractic had emerged in reaction to perceived failings in nineteenth century medical orthodoxy, and in opposition to drug-based therapies. They shared in common with one another a view that the human body had its own inbuilt mechanisms for healing, and that the role of the clinician was to facilitate those mechanisms by removing mechanical obstructions to their efficient working.

Yet Palmer's chiropractic and Still's osteopathy were not identical. Still had emphasised the role of blood and fluids in the maintenance of health in a way that Palmer had not (Still, 1897, pp. 107-108 & 218-219). Still envisioned a divine designer who had placed within each individual all the necessary mechanisms to respond to and cure disease (Still, 1897, pp. 100-101). Palmer saw in his mind's eye a portion of God, which he called Innate Intelligence, working through the nervous system of each person in a very direct way to prevent and combat disease. Still was a registered medical doctor (McLaughlin, 1883), Palmer was not. As a rule, the students of Still and Palmer attended different schools, and through their education they were socialised into different perspectives. Many different techniques of manipulation were taught at the various schools, creating clinical diversity. It was natural for both osteopaths and chiropractors to consider their chosen mechanotherapy superior to others, and for the similarities between osteopathy and chiropractic to act as a source of tension between them.

Even so, in Britain practitioners could move between the titles 'osteopath' and 'chiropractor' as they saw fit, and some did. In point of fact, both Arthur Eteson and Godfrey Heathcote (who in due course returned to Britain), came to describe themselves as osteopaths. Eteson studied at the British School of Osteopathy in London during the 1920s (British School of Osteopathy, 1927, back matter, unnumbered page), but even before that he had described himself as an osteopath (Eteson, circa 1911). Both Eteson and Heathcote registered with the British Osteopathic Association (British Osteopathic Association, 1938).

Why, having undertaken chiropractic training in the United States, did Eteson and Heathcote come to describe themselves as osteopaths in Britain? Was there an advantage for them in doing so? It is probably reasonable to assume that they shared a philosophical and social affinity with others who described themselves as osteopaths, but there may have been more to it than that. It is possible that their decisions, either wholly or in part, rested upon the fact that in Britain, in the early part of the twentieth century, osteopathy was almost certainly

better known than chiropractic. It had a more visible presence. Still's osteopathy had been introduced to Britain before Palmer's chiropractic. Martin Littlejohn had prioritised the founding of a British osteopathic school, a decision critical to the establishment of osteopathy in this country and to the development of its British identity. In the first quarter of the twentieth century there can be little doubt that there were more persons who described themselves as osteopaths in Britain than there were those who described themselves as chiropractors. Osteopaths were generally better organised than their chiropractic counterparts. In 1920 there was neither a national association of chiropractors in Britain, nor a British chiropractic school, whereas both existed within osteopathy. Potentially, therefore, describing oneself as an osteopath, rather than as a chiropractor, conferred an advantage to the practitioner in the marketplace, because potential patients were more likely to have heard of osteopathy than chiropractic.

Even if describing oneself as an osteopath conferred business advantage, chiropractic itself established a foothold in Britain. According to Sir Holburt Waring (1925, pp. 681-682), the initial growth of chiropractic and osteopathy in Britain owed much to the fact that both groups played upon the desires of patients for a clear and simple explanation of their condition, a definite remedy, and an associated sense of mystery. Medical consultations, it would seem, did not always offer these. In addition, chiropractors and osteopaths advertised their services to the public, something that medical doctors were not permitted to do (British Medical Association, 1926, p. 10; General Medical Council, 1926, p. viii-x; Irvine, 1991).

Although the first chiropractors and osteopaths to practice in Britain would have wished patients to come to them with their health problems rather than going to see orthodox medical doctors, the reality was that many of those who consulted chiropractors and osteopaths probably did so following unsuccessful medical interventions. It is perhaps understandable that the suffering patient who had failed to gain relief from orthodox therapy might have turned to the osteopath, or to the chiropractor. For some, what might have been perceived as the new and unusual nature of these therapies might have attracted their interest. For others, it may have been links to more traditional forms of healing, particularly bonesetting. The therapeutic naturalism and therapeutic conservatism of chiropractic and osteopathy might have acted as a draw. In the case of chiropractic, Palmer's theory of subluxations might have appealed in its simplicity. Be that as it may, the number of patients who consulted osteopaths and chiropractors was proportionally very small in comparison with those who consulted medical doctors. Osteopaths and chiropractors practised on the margins of British healthcare.

As regards those from the British Isles who might have wished to study either chiropractic or osteopathy in the United States, in view of the distance involved it is reasonable to assume that costs would have been prohibitive for some, and those who made the journey would either have had to have been fairly well off, or prepared to make financial sacrifices. This tended to distinguish those who studied chiropractic or osteopathy in the United States, and who subsequently returned to practise in Britain, from traditional bonesetters and others who chose to describe themselves as chiropractors or osteopaths. It is notable, for example, that one of the first British students of chiropractic at the Palmer School in Davenport was Lord Charles Kennedy, later to become the Fifth Marquess of Ailsa (The Chiropractor, 1911b).

According to the *Osteopathic Blue Book* (General Council and Register of Osteopaths, circa 1958, p. 10), in its early days osteopathy in Britain was “a rich man’s medicine...an American novelty for which one had to pay almost excessively”. Herbert Eason, Principal and late Vice-Chancellor of the University of London, stated in 1937 that (British Medical Journal, 1937, p. 716):

The idle rich frequented the osteopath, the chiropractor, and other miracle mongers, and the ignorant poor patronized the herbalist. In between them the solid business and professional classes trusted their doctor as they did their lawyer, their stockbroker, and other professional advisors.

Chiropractors and osteopaths practising in Britain made extravagant claims for their treatments. They advertised their services in the lay press (for example: Bolt, 1922; St. John Doherty, 1926; Wade, 1926; McKeon, 1927). They were inclined to advocate a vision of manipulative practice in which the value of manipulation, or adjustment, was seen to extend far beyond the treatment of structural and functional faults within the body’s framework, to include a wide range of abnormalities affecting the organs. The writings of Henry Jones are a case in point. Whilst maintaining that there was no panacea for all ills, and that the earliest chiropractors in North America had claimed too much (assertions that are in themselves notable because they represent a dilution of the principles of Palmerian chiropractic), Henry Jones (1926, pp. 58-59 & p. 68) linked the compromise of nerves exiting the spinal column to disorders that affected the bowels, breasts, ears, eyes, gall-bladder, heart, kidneys, liver, lungs, ovaries, pancreas, skin, spleen, stomach, thyroid, tonsils and uterus. He implied that through manipulation of the spine chiropractic might be beneficial to those suffering from appendicitis, asthma, bronchitis, constipation, deafness, delirium, dyspepsia, epilepsy, fevers, infantile paralysis (polio), insomnia, memory loss, menstrual disorders, peritonitis, pleurisy, pneumonia, shingles, tuberculosis and worms. In accordance with Palmerian

philosophy, a British periodical entitled *The Chiropractor* (not to be confused with the North American publication of the same name) contended that ‘vital energy’ was transmitted from the brain to every organ and part of the body through the spinal cord and nerves (The Chiropractor, 1930b). Amongst other cases, it presented instances of acute appendicitis, asthma and astigmatism in which it was claimed that chiropractic treatments had been of benefit to patients (The Chiropractor, 1930a & 1930c). Ethel Mellor (1931, p. 136 & p. 204) claimed that all diseases of the mind and body fell within the scope of osteopathy; that the keystone of osteopathic theory and practice was the diagnosis, and correction by means of manipulation, of ‘spinal lesions’; and that use of manipulation was advantageous in the treatment of disturbances to internal organs. We cannot know what was in the minds of those who made these claims. We cannot know the true extent of their beliefs. Nevertheless, such claims had propaganda value.

Whilst chiropractors and osteopaths advertised their services to the public, within the confines of the medical orthodoxy advertising and canvassing for patients were considered unethical and unprofessional. As Morrice (1994) has highlighted, between 1922 and 1927 even ‘indirect advertising’ in the lay press was frowned upon. Registered medical doctors could not sign articles about medicine, diet, or hygiene without running the risk of disciplinary action. As a matter of fact, in 1925 William Lloyd, a medical doctor who was an advocate of naturopathy, was struck off the medical register for indirectly advertising his practice by including in an article about the naturopathic treatment of hay fever his address and clinic times, even in the absence of his name (Morrice, 1994, p. 274).

Although chiropractors and osteopaths were at a competitive disadvantage with respect to members of the medical profession in view of their lack of state sanction, they were, on the other hand, able to take a more relaxed attitude towards the ethics of advertising. By making bold claims for their therapies, and by advertising, they attracted patients, establishing a place for themselves within the healthcare market, even though these strategies ran counter to the traditional vision of ‘gentlemanliness’ and professionalism within British society.

4.3 Conclusions

From the foregoing discussions it may be concluded that the beginnings of chiropractic in Britain were more complex and chaotic than might have initially been assumed. Chiropractic in Britain was not simply an import from the United States. It was more than that. It was an occupational group whose origins were influenced by the prior history of manual therapy in

Britain, and whose initial development in Britain was dependent upon the nature of the seedbed in which it found itself.

The first individuals to call themselves chiropractors in Britain practised legally under common law, but they were excluded from the medical mainstream, separated from the profession of medicine by Acts of Parliament that had been passed in the nineteenth century. Their lack of state sanction accorded chiropractors a competitive disadvantage in respect to the profession of medicine, but their separation from medicine also provided opportunities. Chiropractors did not have to abide by the medical profession's ethical standards. They were free to advertise and vie for trade in ways that medical doctors were not. They made enterprising and audacious claims for their treatments, and they promoted a wide scope for chiropractic practice.

To begin with chiropractic in Britain could not easily be distinguished from osteopathy, nor from bonesetting. Together chiropractic, osteopathy and bonesetting formed an unorthodox pluralism of manipulative therapy. If chiropractic was to develop into a distinct and separate profession it would have to become more clearly differentiated from both bonesetting and osteopathy. A dividing line would have to be drawn between those who would be considered chiropractors, and those who would not. Issues of differentiation are considered in the next chapter.

CHAPTER 5

Differentiation and Organisation

Following the discussions on bonesetting, chiropractic and osteopathy contained within chapter 4, it is possible to summarise their situation as follows. By the end of the First World War the practice of traditional bonesetting was declining in Britain. Two ‘new’ manipulative therapies, chiropractic and osteopathy, had begun to establish themselves. Although osteopaths and chiropractors attached different labels to their activities, they were not clearly differentiated from one another. They were marginal and heterodox. Chiropractic in particular lacked appreciable professional organisation.

In this chapter the intention is to address issues relevant to the history of chiropractic’s professionalisation in Britain that naturally stem from the discussions in the last. The chapter seeks to address: (1) How, in the years prior to World War II, the issue of chiropractic’s lack of differentiation from osteopathy was dealt with; (2) How and why chiropractors sought to develop organisational structures to defend their interests; (3) How schisms within chiropractic influenced events. Before drawing to its conclusion, the chapter focuses on attempts by osteopaths to achieve statutory recognition for their occupation during the 1930s, and the implications for chiropractic.

5.1 The problem of differentiation

Fundamental to the idea of the ‘profession’ is differentiation. A body of persons undertaking the same form of work cannot reasonably be considered to be part of a profession if they are largely indistinct from others. A sense of discrete identity must exist not only in the minds of those actively involved in the specific area of work, but also more generally.

In the course of the professional development of an occupation one might perhaps expect differentiation to precede organisation, for groups who have already developed distinct knowledge and expertise to then seek organisation in order to protect their interests. The reality, however, can be more complicated. This is because a clear-cut demarcation in knowledge and expertise between one occupational group and another can sometimes be elusive; because the situation can be confused by intra-occupational diversity in beliefs and practices; because organisation can come to exist in the absence of well-defined

differentiation of knowledge and expertise; and because organisation can itself act as a means to differentiation.

Fields of learning and skill have often been contested between groups, and occupational boundaries have been dynamic (Nancarrow & Borthwick, 2005). It has not always been possible for specific groups of practitioners to obtain an exclusive hold over particular fields of knowledge, or over particular workplace tasks. The professionalisation of midwifery in Britain, for example, as well as being a history of gender-based exclusion and inclusion, has involved competition with the medical profession for control of key aspects of healthcare provision in pregnancy, birth and post-partum (Donnison, 1977; Witz, 1990; Witz, 1992, pp. 104-127; Macdonald, 1995, pp. 144-149). Midwives have not gained exclusive control of these areas. Similarly, the field of manipulative healthcare has been a contested domain. The pioneers of chiropractic in Britain did not enter a territory that was unoccupied. Bonesetters, medical doctors and osteopaths were there before them, and competition between the different groups was to be expected. Although in the first quarter of the twentieth century bonesetting was declining and manipulative surgery was a minority interest within medicine, osteopathy was in the midst of establishing itself. Osteopathy was closely related to chiropractic, and like chiropractic its primary therapeutic tool was manipulation. In respect to their fields of expertise, osteopathy and chiropractic were similar.

In spite of this, it seems that many of those who called themselves 'chiropractors' in the initial years of chiropractic's development in Britain saw their practice as being fundamentally different from osteopathy. Why? On the one hand it must be recognised that there were several philosophical and practical differences between osteopathy and chiropractic with which, one assumes, those who called themselves chiropractors would generally have been familiar. It was true, for instance, that Andrew Still had emphasised the role of blood and fluids in the maintenance of health in a way that Daniel Palmer had not, and that the manipulative techniques employed by osteopaths and by chiropractors were not wholly the same. On the other hand, those traits that chiropractors and osteopaths shared in common were almost certainly more significant than those that separated them. Chiropractic and osteopathy were both systems of manipulative therapy grounded in the belief that bony displacements caused disease. That being the case, an additional explanation is needed to account for the 'sense of dissimilarity' that chiropractors felt in respect to osteopathy. Arguably it was processes of socialisation that were the primary force in separating chiropractic from osteopathy in the minds of chiropractors. Those who studied at the Palmer School of Chiropractic, for example, were taught that chiropractic offered something distinct and special. This view was reinforced by peers and by positive experiences of chiropractic in

clinical practice. Chiropractic's skirmishes in North American courts, with medicine and with osteopathy, encouraged chiropractors to passionately defend their image of difference.

In his book on osteopathy entitled *The New Healing* (1932, pp. 123-137), Streeter, reflecting upon the development of chiropractic, contended that it was a parasitic system based on an imperfect and ill-digested interpretation of osteopathic theory, and that it had enjoyed the popularity that it had mainly because confusion had existed in the public mind between it and osteopathy. Whether or not Streeter's criticism of chiropractic was just, the fact remained that if there was confusion in the public mind there must have been reason for it. Still's osteopathy and Palmer's chiropractic were not sufficiently different from one another for the differences to be obvious to all. Indeed, the patient who consulted either the chiropractor or the osteopath was likely to have had quite a similar experience. Essential to the clinical interaction in each case was an examination intended to identify misalignments within the framework of the body, particularly within the spinal column; and in each case manipulation was the treatment of choice, employed with the aim of restoring structural alignments where abnormalities were found (for example see: British Osteopathic Association, circa 1925; Garsia, circa 1926, pp. 44-45; Henry Jones, 1926, p. 31; Streeter, 1932, pp. 239-240). That individual chiropractors or osteopaths considered themselves different from one another, was, one might argue, beside the point if the general public did not appreciate the differences between them.

The issue of chiropractic's differentiation from osteopathy was complicated by diversity in the detail of beliefs and approaches amongst those who called themselves chiropractors and osteopaths. A significant number of those who called themselves chiropractors did not practise 'pure' Palmer-inspired chiropractic (see: Minifie, 1928). There were chiropractic 'straights' and there were chiropractic 'mixers'. Likewise, a significant number of those who called themselves osteopaths did not practise 'pure' Still-inspired osteopathy (see: McKeon, 1933, pp. 30-31). Additionally, there were those practitioners who moved between use of the two titles (see p. 71). Such diversity made the precise definitions of chiropractic and osteopathic identities more difficult, and this in turn made the matter of inter-occupational differentiation more complex. Issues of inter-occupational differentiation were thus bound to issues of occupational identity.

How, given the substantial overlap in beliefs and practices between osteopathy and chiropractic, and given the intra-occupational diversity that existed, could chiropractic become visibly differentiated from its osteopathic rival? In order to begin to answer this question one must understand that occupations can be differentiated from one another not

only in respect to what they do, the services that they provide within society and the knowledge that sustains those services, but also in respect to other characteristics. An occupational group can, for example, be separated from its competitors in the way it uses language to describe its activities, through the existence of exclusive organisational structures such as schools and associations, or by means of a specific statutory register.

In the years following the First World War there was no immediate prospect of a statutory register of chiropractors in Britain, however, in the absence of clarity of distinction in relation to practice methods, chiropractors with links to Bartlett Palmer and to the Universal Chiropractors' Association in the United States did attempt to differentiate themselves more clearly from their competitors through the use of distinct language and through organisation. In section 5.2 consideration will be given to the initial organisation of chiropractic in Britain, but before that the theme of language warrants focused attention.

Where dissimilarities in clinical procedures between two or more groups of practitioners may not be obvious to external observers, use of distinct language can be used to provide an air of difference. In this respect developments in North American chiropractic had a bearing on chiropractic in Britain. In chapter 3 (p. 54) it was affirmed that in the first decades of the twentieth century chiropractors in the United States attempted to defend themselves in the courts by claiming that distinctive language demonstrated chiropractic's difference from medicine. Wardwell (1992, p. 68) has described a number of the ways in which Bartlett Palmer and his allies used language to attempt to distinguish chiropractic from medicine and from osteopathy. Chiropractors, it was maintained, did not 'diagnose', they 'analysed'. They did not 'manipulate' their patients, they 'adjusted' them. They focused their attention on the 'chiropractic subluxation', rather than on what osteopaths had come to refer to as the 'osteopathic lesion'. As x-rays came to be used within chiropractic with the aim of aiding in the identification of subluxations, chiropractic spinal x-rays were branded 'spinographs'. Those who studied chiropractic in the United States, and who subsequently practised chiropractic in Britain, brought with them this distinct use of language.

At this point it is also appropriate to recognise a change that occurred within osteopathy following the death of Andrew Still in 1917 that had implications for chiropractic. As Miller (1998) has highlighted, following Still's death there was a perceptible shift in the rhetoric used by osteopaths in the United States in discussions about drug therapies. Although Still's writings on osteopathy reveal an opposition to the use of drugs in treating diseases, after his death osteopathic writings came increasingly to acknowledge a place for prescribed medications in the care of patients. Consequently, osteopathy in the United States came to be

more attuned to medicine, and less in accord with Palmerian chiropractic. Bartlett Palmer maintained a vehement opposition to the use of drugs in therapy. His followers, including those who practised in Britain, tended to concur.

Differences in the terminology and rhetoric of chiropractors and osteopaths were not sufficient to clearly differentiate the two groups in Britain. There was a great deal of overlap between osteopathy and chiropractic, and to a significant extent the two occupations remained indistinct from each other. If chiropractic was not to merge with osteopathy, if it was to professionalise in and of itself, it would be necessary for a clearer partition to be erected between the practitioners of chiropractic and osteopathy. In the absence of state licensing, there was potential market advantage to be had in chiropractors uniting, establishing authority, and taking collective action to protect job territory – forming an association, or associations. As it happened, and as the next section will detail, to a greater or lesser extent external pressures forced the hand of chiropractors. North American trained chiropractors found themselves in a situation where in defence of their practice they felt compelled to act both to try to distinguish themselves from osteopaths and to try to clarify the chiropractic identity. As events unfolded they were influenced both by strains acting upon chiropractic from the outside, and by strains acting internally.

5.2 The initial organisation of chiropractic in Britain

The initial organisation of Palmerian chiropractic in Britain was not, as one might have expected, principally the result of a proactive strategy on the part of chiropractors. Rather, it was first and foremost a defensive and reactive response to events whose origins were outside the control of chiropractors, events that can be traced back to actions of the General Medical Council.

In the early years of chiropractic's development in Britain chiropractic was to all intents and purposes 'tolerated' by the medical profession. The attitude of the General Medical Council towards chiropractic and osteopathy was not positive, but the GMC was essentially powerless to directly intervene in their work unless individual chiropractors or osteopaths claimed to be medical doctors (Medical Year Book, 1925, p. 53). The GMC had little option but to accept their existence. What it could do, and what it chose to do, was to discourage registered medical doctors from interacting clinically with osteopaths and with chiropractors by threatening disciplinary action and removal from the medical register. From 1920 onwards, the GMC issued a "Warning Notice" about professional misconduct at the front of editions of *The Medical Register* (Smith, 1993; Morrice 1994). With respect to association

with “unqualified persons”, the notice that was approved by the Council in 1923 read (General Medical Council, 1926, p. ix):

Any registered medical practitioner who, either by administering anaesthetics or otherwise, assists an unqualified or unregistered person to attend, treat, or perform an operation upon any other person, in respect of matters requiring professional discretion or skill, will be liable on proof of the facts to have his name erased from the Medical Register.

It would seem that in or about 1924 some medical doctors received a copy of this warning notice in which the section about associating with the “unqualified” was underlined (Streeter, 1932, p. 213). Wilfrid Streeter, an osteopath who had been working with an anaesthetist on cases of deafness, found himself having to suspend his ‘finger surgery’ operations after his anaesthetist telephoned him to say that he could no longer assist him in view of the risk to his medical registration. Concerned, Streeter contacted Arthur Greenwood MP, Parliamentary Secretary to the Minister of Health. He found Greenwood sympathetic, and the matter of the GMC warning notices was raised in the House of Commons (Hansard, 1925). Greenwood went so far as to suggest in Parliament that new legislation should be introduced to recognise and regulate “osteopathy, bonesetting, and other new methods of treatment”. A request for a deputation to the Prime Minister was turned down, but members of the British Osteopathic Association did subsequently meet with about thirty Members of Parliament (British Medical Journal, 1925a; British Medical Journal, 1925b).

No new legislation resulted from the discussions of osteopathy at Parliamentary level, however, in the context of the current discourse two things are notable. The first is that those medical doctors who continued to have associations with osteopaths were not struck off the medical register (Streeter, 1932, p. 217). This might imply that the phrase “in respect of matters requiring professional discretion or skill” was too imprecise as to form a firm basis for action, or that the GMC was apprehensive about the political repercussions of removing a doctor from the medical register for associating with an osteopath. The second, which is of key importance, is that discussions about the statutory regulation of osteopathy inclined a number of chiropractors with allegiance to Bartlett Palmer to become formally organised in Britain with a view to protecting their interests. These were individuals who had studied chiropractic in the United States. They stood for straight chiropractic, they were opposed to mixing what they saw as genuine chiropractic with other methods, and they viewed chiropractic as separate and distinct from osteopathy.

Although there had been talk of forming a British association of chiropractors as early as 1920 (Bannister, 1920, p. 49), and whilst an association called the Chiropractors' Association of the British Isles had briefly come into existence in 1922 (Bannister, 1922), it was in 1925, when Bartlett Palmer visited England, that the British Chiropractors' Association (BCA) was formally established. It was set up with Palmer's backing to "handle Chiropractic, assist in its growth and be prepared for protective measures" (The European Chiropractor, 1933).

The founding of the BCA was vital to the early professionalisation of chiropractic in Britain. Soon after the formation of the BCA an insurance scheme was introduced to protect members in the event of malpractice claims, and a code of ethics was drawn up to guide them in their conduct. Annual conferences were arranged, initially to consider the business of the Association and for a social dinner, but they soon also included educational content. From 1930 the Association produced a journal, *The Progressive*, which changed its name to the *British Chiropractors' Association Journal* in 1933. The BCA provided opportunities for formal networking, for the promotion of group interests (see p. 18), and for the development of 'professional culture'. By professional culture is meant the social 'values' of the group, including its core beliefs; its 'norms', including guides to acceptable and unacceptable behaviour; its 'symbols', that is to say items that communicate meaning about the group, such as dress (clinical attire) and argot (distinctive language); and the notion of a professional 'career' (See Greenwood, 1966, pp. 16-18).

Even though fewer than 20 individuals came together at the time of the founding of the BCA, its membership soon grew. The Association's Directory for 1926-1927 listed 35 members (British Chiropractors' Association, 1926). By 1930 there were 39 members; by 1935, 56 members; and by 1939, 75 members (British Chiropractors' Association, 1930, 1935 & 1939a).

The Association's *Constitution and Rules* (British Chiropractors' Association, circa 1926) stated:

6 (a) – All new members of the Association shall be duly trained and qualified Chiropractors, who have undergone a Residential Course of not less than two years and possess a Diploma from a Chiropractic School or College recognised by the Universal Chiropractors' Association [the Association set up by Bartlett Palmer and his colleagues in the United States in 1906].

(b) – No applicant shall be admitted as a member of the Association who does not practise “straight” Chiropractic, and whose methods of dealing with patients are not strictly confined to the adjustment of the spine by the application of the bare hands.

The influence of Bartlett Palmer on the early history of the BCA should not be underestimated. To a significant extent he dictated the direction that the Association took in its first years, and the membership looked to him for leadership and guidance. The BCA’s links with Bartlett Palmer and with the Universal Chiropractors’ Association afforded it influence and credibility within an emergent international chiropractic community. The authority of the Association was strengthened when in 1932 members of the BCA were instrumental in establishing formal ties with chiropractors in other parts of Europe through the launch of the European Chiropractic Union (Wilson & Keating, 2007, pp. 19-21).

Members of the BCA were expected to practise only straight chiropractic. Those who did not meet the entrance requirements of the Association were not allowed to join. As well as being a requisite of ideology, it is conceivable that there was a more practical reason for the BCA’s insistence on straight chiropractic. In a climate where legal action against practitioners of manipulative therapy by dissatisfied patients was a distinct possibility, something evident from the legal claim made against Herbert Barker in 1911 (British Medical Journal, 1911a), there might have been a pragmatic incentive for limiting the diversity of practice methods used by members of the BCA for reasons of mutual protection. In 1930 Lannan Floyd McKeon was refused membership in view of the fact that he had not undertaken a course of residential study in the United States approved by the Association (Scott, 1930). Concern was raised about the memberships of Albert and Annie Garratt when information came to light that suggested that they practised as chiropodists as well as chiropractors (British Chiropractors’ Association, 1925-1935). The Garratts were not alone in having questions asked about their scope of practice and about their commitment to straight chiropractic (Copland-Griffiths, 1991, p. 214).

From the foregoing discussions it may be concluded that the BCA came into existence when it did, and in the form that it did, in significant measure because of the series of events that followed the GMC’s issuing of warning notices to medical doctors advising them not to associate themselves professionally with unregistered healthcare practitioners. A response from osteopaths to the warning notices led in turn to defensive action on the part of chiropractic straights. It is paradoxical that a measure that was certainly not intended to encourage unorthodox practice, was instrumental in the formation of the BCA.

It is necessary to recognise that the BCA represented but one contingent of those who called themselves chiropractors in Britain in the pre-World War II period. There were others who described themselves as such, many of whom did not practise straight chiropractic, who advocated mixing, and who, through their beliefs and practices blurred the boundary between chiropractic and osteopathy. Attention is now turned to the initial organisation of some of those who held the middle ground between chiropractic and osteopathy.

Following the formation of the BCA, William Minifie wrote (Minifie, 1928, p. 5):

If you find you can propel your boat better with one oar, after the manner of the Venetian gondolier, “get on with it”, but don’t find fault with those of us who have found by experience that our boat makes greater headway against wind and tide, when we ply TWO oars instead of one; those two oars being Chiropractic AND Osteopathy, mutually complementary, and NOT as some say, contradictory.

During the 1920s and 1930s those who mixed ‘chiropractic’ with other drugless approaches organised themselves into a number of groups, and for a time, educationally at least, would seem to have had a competition-orientated advantage over the straights. Whereas the BCA recognised only those who were graduates of particular North American schools, ‘chiropractic’ methods were taught within the curricula of at least two British schools of natural therapeutics during the 1920s. Instead of having to travel to the United States, a formal education in chiropractic could, it would seem, be obtained in Britain.

The first British school to include elements of chiropractic within its curriculum was probably one founded by William Looker in Manchester in or about 1921. According to Spencer (1923), who was a student of the school (House of Lords Select Committee, 1935, p. 237), having been brought up in England, Looker had travelled to the United States where he had engaged in the study of mechano-therapy, naturopathy, chiropractic, medicine, and osteopathy, and where he had become a successful practitioner. Spencer informs us that Looker obtained a chiropractic qualification from the National College of Chiropractic, in Grand Rapids, Michigan, in 1913. This is intriguing because there is no mention of a National College of Chiropractic in Grand Rapids in the historical directory of chiropractic schools that was produced by Ferguson and Wiese (1988). There is also no mention of it in the *History of Chiropractic Education in North America* produced by Keating, Callender and Cleveland (1998). That is not to say that the school did not exist, for many chiropractic schools came and went in the United States during the first quarter of the twentieth century, and it is conceivable that relevant records have been lost, or that they remain hidden. It is also possible that Looker obtained his chiropractic qualification from the National School of

Chiropractic in Chicago, an institution that is known to have encouraged mixing, or instead from the Michigan College of Chiropractic, which was in Grand Rapids. Whatever the case may be, another question arises. Why, given his apparent success in the United States, did Looker return to England? Perhaps one reason was because in 1919, in spite of the medical qualification that it was claimed he had, Looker was indicted for practising medicine without a licence in Philadelphia (Fountain Head News, 1919 & 1920).

The school that Looker set up upon returning to England was known until 1923 as the Manchester School of Osteopathy and Bloodless Surgery. In 1923 it was incorporated as the Looker College of Osteopathy and Chiropractic Limited (Looker College of Osteopathy and Chiropractic, 1923a & 1923b). In 1925 it was moved from Manchester to London (Looker College of Osteopathy and Chiropractic, 1925). According to an oral testimony provided by Martin Littlejohn in 1935 (House of Lords Select Committee, 1935, p. 239), it may have been possible to obtain a diploma in chiropractic after no more than six months of study at the Looker College. In comparison, by the 1920s the Palmer School of Chiropractic in Iowa required students to successfully complete a minimum of twelve months training (spread across two years) before receiving a chiropractic diploma, although eighteen months training (spread across three years) was the norm (Keating, Callender & Cleveland, 1998, pp. 37-38).

Another school, established in 1925, was the British College of Chiropractic. Originally founded in London, where it had temporary headquarters, it was moved to Plymouth under the direction of Thomas Mitchell-Fox, an individual who had studied at the Looker College (McKeon, 1933, p. 140; Collins, 2005, p. 317). The British College of Chiropractic offered a three-year programme, leading to a Diploma in Chiropractic. Naturopaths, osteopaths and medical doctors were permitted to take a shorter nine-month course (McKeon, 1933, p. 143). Significantly, the British College of Chiropractic was very closely associated with an osteopathic teaching establishment, the Western Osteopathic School.

Neither the Looker College of Osteopathy and Chiropractic, nor the British College of Chiropractic, was recognised by the British Chiropractors' Association, it being opposed to mixing, and of the opinion that the 'chiropractic' education that they provided was inadequate. With respect to the sociological framework that informs this thesis, it is necessary to recognise that these schools presented a challenge to the purity and boundaries of chiropractic. If Wilensky (1964, p. 142) was right in his assertion that professionalisation requires a full-time commitment to a task that needs doing, then the mixing of chiropractic and osteopathy presented a further obstacle for chiropractic in professional terms, for the focus on chiropractic itself, in education and in practice, was reduced.

Given that the BCA would not accept diplomas from these schools as satisfactory grounds for membership of its association, those who had studied at them were obliged look elsewhere if they sought organisation and group cohesion. Those from the Looker College could not join the British Osteopathic Association, as it did not recognise their qualification (Collins, 2005, p. 21), but as some who had studied there were drawn to osteopathy, former pupils of the Looker School formed the Incorporated Association of Osteopaths in 1925 (McKeon, 1933, p. 113). The British Chiropractic Society was set up to provide for graduates of the British College of Chiropractic. It was affiliated with the British Naturopathic Society. From 1928 it produced a journal, *The Spinal Curve*.

As it turned out, events unfolded in such a way that former students of both the Looker College, and of the British College of Chiropractic, came increasingly to associate themselves with osteopathy, rather than with chiropractic. Doubtless a number of influences affected this outcome, some of which were described in chapter 4 (pp. 71-72). In addition to these, and besides the stance taken by the BCA, three factors are worthy of particular attention here.

The first was a change in the state of affairs at the British School of Osteopathy in London, a change that almost certainly encouraged openness from those at that school towards pupils of the Looker College, and of the British College of Chiropractic. Prior to 1926 the British Osteopathic Association had generally been supportive of the British School of Osteopathy, but during 1926 a difference of opinion between Martin Littlejohn, who was Dean of the School, and officials of the British Osteopathic Association, led to the removal of that support. Essentially, the BOA sought to exercise its authority in the running of the School, something that was resisted by Littlejohn, who wished to keep it under his control (British School of Osteopathy, 1927, p. 11). Consequently, the BOA ended its co-operation with the School. Members of the Association were discouraged from working at the School, and graduates of the BSO were from that point on refused entry into the BOA (O'Brien, 2007, pp. 38-39). In losing the backing of the BOA, Littlejohn also lost endorsement for his school from the American Osteopathic Association, with which the BOA was closely connected. This would prove to be an important moment for osteopathy in Britain, one that would alter its dynamics. Littlejohn found himself in an awkward situation. It is reasonable to assume he appreciated that if he were able to make new allies it might bolster his position.

A second factor that came into play at this time was the fact that in 1926 William Looker died. Following his death his school closed and negotiations were initiated between the Incorporated Association of Osteopaths and the BSO with the intention of forming a new

partnership (McKeon, 1933, pp. 113-115). As a result of the negotiations, having undertaken additional studies, those members of the Incorporated Association of Osteopaths who so wished would become eligible for the diploma of the BSO. About fifteen persons took this route (Collins, 2005, p. 21). In return, graduates of the British School of Osteopathy came to be accepted into the Incorporated Association of Osteopaths (Incorporated Association of Osteopaths, 1929).

The third factor that influenced matters was that the British College of Chiropractic proved less successful than Thomas Mitchell-Fox would have wished. The College had its first graduation ceremony in 1928, but there were only two graduates, William Minifie and Lannan Floyd McKeon (*The Spinal Curve*, 1928). In due course, Mitchell-Fox came to the conclusion that his school was not viable, for there was difficulty in obtaining suitably qualified lecturers and a paucity of students wishing to enrol (McKeon, 1933, pp. 143-144). Some of those who had studied at the British College of Chiropractic applied and were admitted to the British School of Osteopathy, credited for the work they had undertaken in Plymouth. Although there was an effort to bring about co-operation with the British Chiropractors' Association, it did not meet with success (*The Spinal Curve*, 1929; McKeon, 1933, p. 145). The British Chiropractic Society continued to exist into the 1930s. After a while, its journal, *The Spinal Curve*, was incorporated into *The British Journal of Natural Therapeutics*.

5.3 The question of osteopathic legislation

In the years before World War II the number of chiropractors and osteopaths practising in Britain who were organised into associations was not large. In the early part of the decade that preceded the War there were two chiropractic associations of note, the British Chiropractic Society and the British Chiropractors' Association. The British Chiropractic Society had only a handful of members and would not survive. A greater number of persons were members of the British Chiropractors' Association. The main osteopathic associations were the British Osteopathic Association and the Incorporated Association of Osteopaths, each with fewer than 100 members (House of Lords Select Committee, 1935, p. 116; Collins, 2005, p. 25). Outside the ranks of these associations were others. Although their number cannot be known exactly, in 1935 it was estimated that there were in excess of 2,000 people who described themselves as osteopaths in Britain (House of Lords Select Committee, 1935, p. 32).

Even in the presence of separate associations of chiropractors and osteopaths, associations that through their existence were instrumental in partially differentiating the two occupations, the boundary between chiropractic and osteopathy remained somewhat obscure in the absence of a statutory dividing line between them. In view of the absence of legal differentiation with respect to osteopathy in Britain, there were those within 'organised osteopathy' who sought through political agitation to bring about its official recognition and regulation. In 1930 the British Osteopathic Association initiated what proved to be an unsuccessful attempt to obtain a Royal Charter for itself (Collins, 2005, p. 55-56). In 1931, however, Wilfred Streeter was successful in instigating a Bill to regulate osteopathy. It was introduced into the House of Commons by William Adamson MP, but Streeter had acted without the support of the British Osteopathic Association, and when concerns were raised, the Bill was withdrawn. It was reintroduced, with amendments, in 1933 by Robert Boothby MP, and then again early in 1934, but it did not become law (Handoll, 1986, p. 15). Finally, in December 1934, an attempt was made to introduce an osteopathic Bill through the House of Lords. On this occasion, the Bill passed its second reading on the understanding that it would be referred to a Select Committee for detailed consideration.

The relevance to this thesis of the attempts by osteopaths to achieve statutory regulation during the 1930s is that an Osteopaths Act had potential to seriously and adversely affect the practice of chiropractic in Britain. In the form proposed, even after its amendments, not only would the Osteopaths Act have raised the profile of osteopathy, its perceived status, and its perceived legitimacy within society, all at the expense of chiropractic; but potentially it would have rendered the practice of chiropractic by those who were not registered as osteopaths illegal. The problem was that the Bill described osteopathy in broad terms as "the performance of any such operation and the giving of any such treatment advice or attendance as is commonly given by osteopaths" (Osteopaths Bill, 1934, clause 2), and it prohibited the practice of osteopathy by unregistered persons (Osteopaths Bill, 1934, clause 8). If osteopathy could not be simply and clearly distinguished from chiropractic, which it could not, then chiropractors would run the risk of being accused of practising osteopathy illegally.

In 1931, therefore, at the time when Adamson's Osteopaths Bill was before Parliament, a petition was sent from the British Chiropractors' Association to members of the House of Commons drawing their attention to the existence of the Association, and requesting that it be recognised (British Chiropractors' Association, 1931). When the Bill was reintroduced into Parliament in 1933 a call for an amendment was made, so that if the Bill passed into law it would not apply to persons engaged in chiropractic (British Chiropractors' Association, 1933). In 1935, when the Select Committee of the House of Lords met to consider the Bill,

St. John Raikes was employed as counsel to represent the British Chiropractors' Association in opposition to the Bill. Other groups that opposed the Bill included the British Medical Association, the Chartered Society of Massage and Medical Gymnastics, and the Nature Cure Association. The objections of the Nature Cure Association were similar to those of the British Chiropractors' Association (Collins, 2005, pp. 67-68).

The report of the Select Committee recommended that the Bill not proceed, and gave three main reasons for its decision (House of Lords Select Committee, 1935, p. iv). First, it was considered that osteopathy was insufficiently established in Britain. Second, in light of a cross-examination of Martin Littlejohn which called into question his academic qualifications and raised concerns about his running of the British School of Osteopathy (pp. 210-212 & 216-259), the conclusion was drawn that the School was inefficient for its purpose, and in dishonest hands. Third, and, of key importance in relation to chiropractic, the Select Committee concluded that no definition of osteopathy had been provided to satisfactorily differentiate its sphere of activity from others. Of particular significance was the fact that there were osteopaths who maintained that they were qualified to treat all diseases, a claim that posed a challenge to the medical profession's established sphere of influence.

Following the report of the Select Committee, an attempt was made to establish a single overarching voluntary register of osteopaths, which was named the General Council and Register of Osteopaths (GCRO). Eligible for inclusion on the register for a ten guinea registration fee were osteopaths from four groups (General Council and Register of Osteopaths, 1937): (1) members of the British Osteopathic Association; (2) members of the Incorporated Association of Osteopaths, which changed its name to the Osteopathic Association of Great Britain (OAGB) in 1936 (Collins, 2005, p. 151); (3) members of the National Society of Osteopaths, which came into existence to represent osteopaths not included within the BOA or the OAGB, for example individuals who had studied osteopathy through apprenticeship (General Council and Register of Osteopaths, circa 1958, p. 25); (4) independents. That the registration fee was payable in guineas is notable, because guineas were traditionally considered more 'gentlemanly' than pounds.

In 1937 there were approximately 80 members of the BOA, 76 members of the OAGB, 100 members of the National Society of Osteopaths, and an unknown number of independents (General Council and Register of Osteopaths, 1937). Although in the period before the War, the vast majority of OAGB members applied for, and were accepted into the GCRO, only about half the membership of the BOA requested to be registered, and for the most part

‘osteopaths’ outside these two associations did not apply (Collins, 2005, p. 163). Why was this? There were a number of reasons, the most basic of which was probably that not all osteopaths saw registration as being in their interest. There was concern inside the BOA about the inclusive nature of the membership, and about OAGB representation (Collins, 2005, pp. 162-163). Initially, full membership was only offered to those who had studied osteopathy at ‘approved’ schools in the United States, but it was not long before it was extended to those who had studied at the British School of Osteopathy (General Council and Register of Osteopaths, circa 1958, p. 26). Others could apply to become ‘associate’ members, for which the same registration fee was payable, but there can be little doubt that this classification would have diminished the incentive to submit an application (even though upgrade through examination became a option). It is possible that some who described themselves as osteopaths were not aware of the register. A number, it may be assumed, were content with the *status quo*, and opposed to ideas of registration and regulation. Those outside associations may not have felt a strong sense a social solidarity with other osteopaths, and for this reason they might have been less likely to apply. It must also be remembered that there were individuals who considered osteopathy to be but one part of their clinical repertoire. There were some who practised other forms of natural healthcare, and also a small number who were medically qualified (British Osteopathic Association, 1938). There were those who did not practise osteopathy full-time, and no doubt there were those who did not intend to continue practising osteopathy long-term, for example those who were due to retire. For these, or other reasons, in the last years before the War the register was comprised of only a minority of those who called themselves osteopaths in Britain. Even though the roll included the names of many of those who had undertaken formal study of osteopathy, it could not be used as a clear means of making the distinction between who was, and who was not, a *bona fide* osteopath. Moreover, it was ineffective in distinguishing osteopathy from chiropractic.

To muddy the waters further, in 1935 a new school, the Edinburgh College of Naturopathy, Osteopathy and Chiropractic proclaimed that osteopathy and chiropractic were complementary to naturopathy, and that it was essential for the practitioner of ‘natural healing’ to include all three in their therapeutic inventory (Edinburgh College of Naturopathy, Osteopathy and Chiropractic, 1935). It advertised that it would teach naturopathy, osteopathy and chiropractic to the intelligent adult student in one year. Those who successfully completed the course were to be awarded a ‘triple diploma’ covering the three subject areas. They would be entitled to join an association, the United Association of Osteopaths, Chiropractors and Naturopaths of Great Britain and Ireland. The School’s Principal, Norman Harris, affirmed in its prospectus that he had studied at the American

School of Naturopathy and Chiropractic, although he did not detail exactly where it was located. Possibly it was a school run by Benedict Lust in New York (Keating, Callender and Cleveland, 1998, pp. 13-14). The Edinburgh College, like the Looker College of Osteopathy and Chiropractic, and like the British College of Chiropractic, was not long lasting. For its part, the British Chiropractors' Association was not involved in any attempt to set up a school in the years before World War II. The time, it was stated, was "not ripe for such a venture" (The European Chiropractor, 1933, p. 7).

5.4 Conclusions

The intention of this chapter was to examine the issues of chiropractic differentiation and organisation in Britain in the years prior to World War II, with particular emphasis on the interplay between chiropractic and osteopathy, themes relevant to the sociological framework of professionalisation because of the need for cohesion in establishing occupational group identity. It was also to consider how schisms within chiropractic influenced events. Additionally, it was to investigate osteopathic endeavours to achieve statutory regulation in the 1930s, and their effect on chiropractic.

The history presented draws attention to the close, but not always cordial relationship that existed between chiropractors and osteopaths working in Britain in the 1920s and 1930s. Of the two occupational groups, osteopathy was the 'senior' in terms of its social presence, and to a significant extent its evolution forced the pace of chiropractic's development. The BCA came into existence when it did, and in the form that it did, largely because of the response of osteopaths to warning notices issued by the GMC advising medical doctors not to associate themselves with the 'unqualified'. In this sense its formation was externally driven, and as such the establishment of the BCA should be viewed as a reactive response to a perceived threat to jurisdiction, rather than as a proactive strategy.

Through the establishment of the BCA, chiropractic 'purists' achieved a measure of social separation from osteopaths that they had not obtained previously. In contrast, there were forces at work that were inclined to promote the intermingling of chiropractic and osteopathy, and groups who encouraged a mixing of drugless healing methods. In this regard, schools established by William Looker, by Thomas Mitchell-Fox, and by Norman Harris, are notable, as are the associations to which they were linked. Martin Littlejohn's actions as Dean of the British School of Osteopathy in connection with students of Looker and Mitchell-Fox changed the dynamics of the ground between osteopathy and chiropractic.

The series of attempts by osteopaths to obtain statutory recognition for their occupational group in the course of the early to mid-1930s prompted the BCA to take action through which representatives of osteopathy and chiropractic came to oppose one another. Had osteopaths been successful in attaining an Act of Parliament, it is likely not only that it would have afforded osteopathy special status in society relative to chiropractic, but also that it would have established control over job territory favourable to osteopathy, and detrimental to chiropractic. As it turned out, the Select Committee's examination of osteopathy found it wanting, and no Act followed. Instead, the Select Committee set out grounds upon which future attempts at osteopathic legislation, and future attempts at chiropractic legislation, might be judged. Before osteopaths approached Parliament again, or chiropractors approached Parliament for the first time, it would be prudent for proponents of legislation to ensure that in Britain the provision of services was widespread and longstanding, that educational standards were high, and that a robust system of voluntary regulation was in place. The problem of occupational differentiation would not go away, and would have to be dealt with in a way acceptable to Parliament if chiropractic or osteopathic legislation was to be passed. These things would take time.

CHAPTER 6

Hindered Development and Reorganisation

The period between 1908, the date when Palmer-based chiropractic was probably first practised in Britain, and 1939, when war broke out in Europe, saw chiropractic in Britain make its first steps on the journey of professionalisation. It was during this time that those who called themselves chiropractors first organised themselves in pursuit of a task that they considered worth doing, namely providing a chiropractic healthcare service to the population of the British Isles. They formed associations. They established minimum standards of entry into those associations. The first code of ethics was produced. Despite this, at the end of the 1930s chiropractic was still a small and insignificant occupation in the context of British healthcare. The distinction between who was, and who was not a chiropractor was not transparent. The title 'chiropractor' and a chiropractic scope of practice were not protected under law. Those who called themselves chiropractors were divided between those who saw chiropractic as a separate and distinct system, and those who mixed chiropractic manual therapy with other forms of healing.

The exact number of people in Britain who described themselves as chiropractors in the years before World War II is not known. There was a UK census in 1931, the last UK census before the war years, but no specific information is available from it relating to chiropractic. Records from chiropractic associations of the time are available for historians to examine, but as the associations had specific entry requirements, they did not recognise all who chose to describe themselves as chiropractors. In 1935, or there about, the European Chiropractic Union (ECU) produced a list of those that it believed to be practising chiropractic in Europe, a list that included both 'straights' and 'mixers' (European Chiropractic Union, circa 1935). The list included 129 individuals practising chiropractic in the United Kingdom, of whom 108 were in England, fifteen in Scotland, three in Wales, and three in Northern Ireland. There may have been many more who described themselves as chiropractors, unknown or unrecognised by the ECU. BCA accounts for 1935 list 56 members (British Chiropractors' Association, 1935). From this it can be deduced that the BCA represented only a minority of those who called themselves chiropractors in Britain in 1935.

The BCA embodied what it considered to be legitimate chiropractic. It sought to distinguish between 'genuine' chiropractors and others, and ventured to ensure that its members

maintained the right to practise chiropractic. Even so, the distinction between chiropractor and non-chiropractor was not always easy to ascertain in Britain prior to 1939, and neither for that matter was the distinction between chiropractor and osteopath. There were schools that purported to teach both chiropractic and osteopathy together within the same curriculum, and there was significant overlap in clinical application of the two disciplines. Both chiropractors and osteopaths emphasised the value of manipulation as a therapy, as of course did bonesetters and those medical doctors who practised manipulative surgery, but unlike the typical medical doctor, the founders of chiropractic and osteopathy, Daniel Palmer and Andrew Still respectively, professed grand theories that gave manual therapy an air of power and mystique, suggesting a value to it beyond the treatment of musculoskeletal disorders, implying that the correct application of manipulation could lead to a general restoration of health and wellbeing.

Although there were similarities in theory and practice, separate associations of chiropractors and osteopaths were set up in Britain that attempted to advance one at the expense of the other. It was osteopaths, rather than chiropractors, who were more progressive in their attempts to professionalise in the years before 1939. The British Osteopathic Association was formed some fifteen years before the BCA came into existence; a successful osteopathic school, the British School of Osteopathy, was established in 1917; and osteopaths lobbied repeatedly for recognition of their occupation by the state, albeit without success, something that chiropractors had failed to do.

In an address to the House of Lords Select Committee in 1935, John Thorpe, Counsel for the British Osteopathic Association, stated that there were 179 people practising as “qualified” osteopaths in Great Britain and Ireland, but suggested that there were no fewer than 2,000 who claimed to be osteopaths, but who were, in his view, unqualified (House of Lords Select Committee, 1935, p. 7). Even if the figure of 2,000 is an over-estimate, the problem of unqualified practice was something that neither British osteopathy, nor British chiropractic had adequately resolved. Where those who called themselves chiropractors and osteopaths disagreed about who was and who was not qualified, the official position of the British Medical Association was simpler. The minimum training necessary for competent diagnosis, something it was assumed chiropractors and osteopaths must do, was successful completion of a course in medicine (British Medical Association, 1935, p. 11). Without a medical qualification, a practitioner was not deemed to be sufficiently qualified.

Having previously examined the history of chiropractic in Britain prior to World War II, chapter 6 seeks to build on the foundations already established by considering the period

from 1939 until 1965. The chapter addresses the negative impact of the Second World War on chiropractic's professional development in Britain; changing attitudes towards 'mixing' in chiropractic; the threat posed to chiropractic by the formation of the National Health Service in 1948; new relationships and educational issues within chiropractic; and the resurgence and reorganisation of chiropractic in the post-war period. As the forthcoming discussions are intended to bear out, this was a period of intra-occupational transformation, a time in which traditional chiropractic principles were questioned, and in which medicalisation of chiropractic occurred. Within the chapter special attention is given to the British Chiropractors' Association. The reason for this is that following the War and the challenges that it presented, the BCA adapted to the environment in which it found itself, increased its authority, and established itself as the main representative body for chiropractors in Britain. It was members of the BCA who were primarily responsible for the founding of the first chiropractic school in Britain to be widely recognised within the international chiropractic community, the Anglo-European College of Chiropractic (known later as the Anglo-European College of Chiropractic), which opened its doors in 1965.

6.1 War and its aftermath

Chiropractic's development, like many aspects of life in Britain, was seriously affected by the Second World War. In preparation for the possibility of war, a *Military Training Act* had been passed in May 1939, which required twenty and twenty-one year old men to undertake six months of armed forces training (Act of Parliament, 1939a). In September 1939 Parliament passed the *National Service (Armed Forces) Act*, whereby men between the ages of eighteen and forty-one became liable for conscription (Act of Parliament, 1939b). In October 1939 conscription began, initially for those between the ages of twenty and twenty-three. A schedule of reserved occupations had been drawn up, so that individuals from certain skilled occupations were exempt from military service, but the list did not include chiropractors. BCA accounts for 1939 suggest that at the time approximately two-thirds of the Association's members were male (British Chiropractors' Association, 1939a). Many of them would have been liable for conscription. On 20th September 1939 the Secretary of the BCA wrote to the Home Secretary (British Chiropractors' Association, 1939b):

The British Chiropractors' Association takes this opportunity of offering the services of its members, as a body, to His Majesty's Government, as it is felt that there will be a pressing need for qualified chiropractors during wartime.

Receipt of the letter was acknowledged by the Home Office, but the offer was not taken up (British Chiropractors' Association, 1939c). In March 1941 another letter was sent from officials at the BCA to the Minister of Labour and National Service (Sandson et al., 1941). It included the following appeal:

Our earlier applications to the Ministry of Health and to the Home Office for official use to be made of our services met with no success, and we therefore earnestly request that, should it still be impossible to make official use of our services as chiropractors, some measure of reservation may be accorded in order that our work may be continued for the general public.

The letter included a brief description of chiropractic, emphasising the educational and legal standing of chiropractors in North America, the skills that chiropractors possessed and details of some of their successes. It cited a chiropractic practice in Edinburgh as one that had recently had to close down due to a lack of practitioners. In writing to the Minister of Labour and National Service, the BCA asked that a deputation of those qualified from "approved schools" be allowed, so that the case of chiropractors in Britain might be heard.

The deputation from the BCA might not have been received were it not for an intervention by Lady Davidson, who was introduced to BCA dignitaries by a chiropractor named Paul Jay (British Chiropractors' Association, 1941a). Lady Davidson secured an interview for BCA officials with Ernest Bevin, the Minister of Labour and National Service. That interview took place at the House of Commons on 3rd April 1941 and was followed by a second interview with Sir William Beveridge, Chairman of the Manpower Selection Board. The intervention of Lady Davidson is an example of the importance of support and action by strategic elites in advancing an occupation's ambitions. That said, the meetings of 3rd April 1941 did not result in reservation of chiropractors. Sir William Beveridge relinquished responsibility for national service and military recruiting not long after his meeting with the chiropractic delegation. According to Harris (1977, p. 377), in May 1942 Beveridge turned his undivided attention to problems of social insurance. His new focus would eventually lead to the formation of the National Health Service (NHS). On 21st June 1941 the BCA received a letter from Lord Terrington in which he informed the Association that its request for chiropractic to be included on the schedule of reserved occupations was declined (British Chiropractors' Association, 1941b). There were unsuccessful efforts by osteopaths to seek reservation (Collins, 2005, p. 200), but no other attempt by a group describing themselves as chiropractors has come to light.

The failure of the BCA to achieve a general exemption from military service for chiropractors meant that those chiropractors who were fit and of appropriate age remained subject to conscription. As a result, the provision of chiropractic services in Britain suffered. It seems that not all of those who were called to support the war effort returned to re-establish their practices afterwards. BCA membership dropped from 75 in 1939 to 35 in 1945 (British Chiropractors' Association, 1939a & 1945a). Although there was a recovery in the years following the cessation of hostilities, with BCA membership increasing to 46 by 1948 (British Chiropractors' Association, 1948), chiropractic's development in Britain was hampered.

Building a successful chiropractic practice was something that would have taken time, a matter of years. Where chiropractic practices were closed as chiropractors were called up, or closed for other reasons connected to the War, the task of re-establishing them after the War would not have been insignificant. Additionally, an unknown number of potential students of chiropractic would have been drafted into national service. Generally speaking, travelling to the United States to study chiropractic was not an option during the War.

Conscription was probably the most important factor that hindered chiropractic's development in Britain during the early to mid-1940s. Chiropractic's professionalisation was set back because of the BCA's failure to convince authorities that chiropractors should be excused military service on account of the benefit they provided to society. Additionally, the care that chiropractors provided was not considered to be of significant military value. Chiropractic was not regarded as sufficiently important to be given special consideration for either civilian or military purposes.

Another factor that affected chiropractic through the course of the Second World War was a serious disruption to its communication networks. In March 1946, Charles Bannister, the President of the ECU, wrote to European chiropractors from Belfast in the first peace time issue of its periodical *The European Chiropractic Bulletin* (Bannister, 1946, pp. 1-2):

The last issue of the Bulletin Vol. 8 No. 5 was sent out on the 15th of June 1940, just after France and Belgium were invaded; and in spite of every effort to keep Chiropractors in contact with each other, the E.C.U. had to become dormant. It was also at this time that the Battle of Britain took place, and Britain itself was threatened with invasion. Many had, as the result, to seek refuge in the country away from the dangers of bombing, while others joined the Fighting Forces, both for Over-seas and Home Defence, some also had their homes bombed and some were killed. During all this time the Bulletin had to lie low...

... Between that date and the end of 1944, except for an odd letter from the Chiropractors in Britain, and a few from Chiropractors in America there was absolutely no news what so-ever of Chiropractors, and all those on the Continent were completely cut off.

Relatively small organisations like the ECU and the BCA lacked the more robust infrastructure of larger bodies like the British Medical Association. Due to an insufficiently high and positive profile within society they also lacked external allies. The loss of a few key individuals, or an inability to effectively communicate with them, would have been highly significant to their workings. Where such individuals became isolated, in Britain and in other parts of Europe, chiropractic's development was endangered.

Osteopathy faced many of the same concerns as chiropractic during World War II. Like chiropractors, osteopaths practising in Britain were called into military service, as were potential students of osteopathy, and osteopaths, like chiropractors, faced difficulties in respect to communication. Records of the British Osteopathic Association show that its membership reduced from 86 in 1938 to 59 in 1948 (British Osteopathic Association, 1938 & 1948; see p. 68 for the origins of this organisation). On the other hand, the membership of the Osteopathic Association of Great Britain actually increased from about 76 members in 1937 (General Council and Register of Osteopaths, 1937) to 93 members practising in Britain in 1949 (Osteopathic Association of Great Britain, 1949; see p. 87 for the origins of the Incorporated Association of Osteopaths, which as described on p. 90 became the OAGB in 1936). Together the combined membership of the BOA and the OAGB fell slightly, but the drop in numbers was less striking than that seen within the BCA. How can this be explained? For one thing osteopathy was longer and more securely established in Britain. One might suspect that the mean age of osteopaths was higher than that of chiropractors (something that it has not been possible to verify). If so, then a greater proportion of osteopaths may have avoided conscription, as the military call up did not involve those in older age groups. More certain is that osteopathy had the edge over chiropractic in the educational arena, an edge that had particular implications for the membership of the OAGB. Whereas during the War there was no school of chiropractic in Britain, and potential students of chiropractic could not generally travel to the United States to study, training of osteopaths continued at the British School of Osteopathy. Although the number of persons who studied osteopathy was small, thirteen individuals receiving their osteopathic diplomas from the BSO between 1941 and 1944 according to Collins (2005, p. 215), there was at least a trickle of new blood into osteopathy, something that was lacking in 'organised' chiropractic. Graduates of the BSO typically joined the OAGB. The fall in BOA membership numbers may be explained by the fact that the BOA only accepted North

American trained osteopaths into its ranks. In this regard its situation was similar to that of the BCA.

6.2 Post-war challenges, responses and reform

Following the War chiropractic faced the need to rebuild. The situation was complicated by a series of challenges that provide the basis for the discussions in this section. First, there was the issue of mixing in chiropractic, and the BCA's stance towards it. Second, there was the proposal to set up a National Health Service, a plan that did not include chiropractic, and that had the potential to drastically reduce the market for chiropractic care. Deliberations over the National Health Service brought to the fore the subject of chiropractic's relationships with external groups more generally. Then there was the matter of chiropractic training. If chiropractic was to thrive, indeed if it was to survive, a new generation of practitioners would have to be trained. Thought would have to be given as to how this might best be achieved. Finally, in addition to the question of mixing, there were other questions about the beliefs that underpinned the Palmerian chiropractic tradition on which there had been intra-occupational disagreement and tension with medicine. Did traditional chiropractic principles warrant re-appraisal? Was chiropractic to remain an 'alternative' to medicine? Was a process of *aggiornamento* (bringing up to date) prudent within chiropractic?

During and after the Second World War the BCA faced a problem of numbers. It was a problem that was of sufficient gravity to threaten its existence, and as such it could not be ignored. If the Association was to endure, it had to adapt. Policy changes were required.

One way in which the Association could potentially strengthen its position was by relaxing its entry criteria, thus increasing the number of those who might successfully apply for membership. In the pre-war years membership of the BCA had been confined to those who had completed specific residential training in North America and who also agreed to practise only 'straight' chiropractic. If the Association was to take a more relaxed stance towards mixing, in theory its situation might be improved. It acted accordingly.

Perhaps the earliest official indication of the change in policy came in 1943 when at the Association's Annual Conference in London Ernest Ashford asked what deviation from the "Chiropractic Principle" (which in its 'purest' form was the doctrine that chiropractic treatment should involve adjusting segments of the spinal column by hand only), if any, the Association considered permissible in granting an applicant membership (British Chiropractors Association, 1943). In the course of the discussions that ensued, the President

of the Association, John Sandison, suggested that there should be a “broad interpretation of the Chiropractic Principle to allow for individuality being expressed by members in their methods of practice”. A vote was taken, and the President’s position was adopted. Mixing became permissible within the BCA.

There were pragmatic grounds for this change in BCA policy, but to assume that the decision was made only for pragmatic reasons would probably be an over simplification. There were new figures in positions of authority within the Association with perspectives and ideas that were different from those who preceded them.

This was a key moment for the BCA. Not only did the new policy lead to a change in the nature of the organisation in and of itself, for as time went by an increasing number of its members chose to practise as mixers; but it also contributed to a reappraisal of relationships with other healthcare groups, for the new policy implied an acceptance of the possible benefits of a variety of methods in the treatment of disease.

With the end of war came the prospect of a new era of social welfare in Britain. In November 1942 Sir William Beveridge had presented a report to Parliament entitled *Social Insurance and Allied Services* (Parliamentary Papers, 1942). In it he outlined a vision for the future, which, he believed, would tackle the “five giants” of want, disease, ignorance, squalor and idleness. The reforms he proposed included a major revision to the way in which healthcare was to be paid for in Britain. He advised that a compulsory national insurance scheme be set up, into which workers would be required to contribute, and from which funds would be drawn for the provision of healthcare and other services. In the White Paper, *A National Health Service*, published in February 1944, the coalition government of the day presented plans for the establishment of the new Health Service (Parliamentary Papers, 1944). The service was intended to ensure that everybody in the country, irrespective of means, age, sex or occupation, would have the opportunity to benefit from the best and most up to date medical care, free (apart from possible charges for certain appliances) at the point of access. Following prolonged and difficult discussions, the *National Health Service Act* was passed in November 1946 (Act of Parliament, 1946) under Clement Attlee’s Labour government, and the National Health Service came into existence in England and Wales on 5th July 1948.

In the discussions that preceded the formation of the NHS, concerns were raised by various groups. Of relevance to chiropractic are the endeavours of those who believed that the NHS would neglect members of the public who chose to seek care from ‘unorthodox’

practitioners. Following the Beveridge Report, a British Health Freedom Society (BHFS) had been formed to protect the interests of such people (Collins, 2005, p. 205). It included members of the public and non-medical practitioners (osteopaths, naturopaths and others), and aimed to ensure that under any new legislation patients would have the right to seek the healthcare services of any practitioner without financial penalty. Having stood vehemently for straight, unadulterated chiropractic in the pre-war period, and having opposed osteopaths in their attempts to achieve regulation under law, in December 1945 the BCA became actively involved with the activities of the British health freedom movement (British Chiropractors' Association, 1945b). This marked a fundamental change in the BCA's policy towards other groups. In order to protect its own interests and those of its patients at a time of weakness, the BCA entered partnership with other natural healthcare bodies. It became part of a Joint Committee of Unorthodox Practitioner Associations (JCUPA), which worked in conjunction with the BHFS. The BCA's change in attitude towards external groups was dependent upon its reappraisal of internal policy, and the reverse was also true.

The BHFS lobbied Members of Parliament. Testimonies were provided in support of the contention that natural healing methods could restore patients to health where orthodox medical methods had failed (British Health Freedom Society, 1946). In May 1946, at the time when the National Health Service Bill was being discussed in Parliament, copies of a letter were sent to members of both the House of Commons and of the House of Lords (Wood & Keeler, 1946). The letter included the following extract:

If the National Health Bill in its present form becomes law, a serious problem will arise affecting large numbers of the public. These people are at present in the habit, both when they are ill and as a preventative measure, of receiving treatment from unorthodox practitioners, because they find from experience that this is the only treatment that does them good. As such treatment will not be available under the National Health scheme, these patients will therefore be faced with the alternative of either submitting to orthodox treatment, to which they have strong conscientious objections, or taking their usual treatment at their own expense.

Well-to-do people are not concerned over this problem, accepting the Health Minister's statement that people will be free to choose their own practitioner of any school of healing and that practitioners will be free to continue giving advice and treatment. But workers cannot afford to pay both their insurance contributions and their unorthodox practitioners.

Although compulsory national insurance contributions for healthcare benefits had been paid by workers since the passing of the *National Insurance Act* in 1911 (Act of Parliament, 1911), it was evident that the more extensive healthcare benefits outlined within the National

Health Service Bill would require higher revenues to realise. Under the provisions of the *National Insurance Act* workers had been provided with cover for medical and sanatorium treatment, essentially the services of a medical doctor in times of sickness and where necessary treatment for tuberculosis. Under the proposals for the National Health Service the entitlement to healthcare free at the point of access was to be extended to all, not only to workers, but to their families and others resident in Britain. The intention was to cover a far more comprehensive assortment of hospital, primary care and community-based services.

Despite the efforts of the BHFS and the JCUPA the *National Health Service Act* did not take significant account of their wishes. Unorthodox practitioners, including chiropractors, were largely excluded from the workings of the NHS. That said, five homeopathic hospitals (located in Bristol, Glasgow, Liverpool, London and Tunbridge Wells) were absorbed into the NHS (Hansard, 2006, col. 1280), and the Minister of Health, Aneurin Bevan, gave assurances that these institutions would be able to provide their own form of treatment and that their characteristics would be maintained (Act of Parliament, 1950, preamble). With respect to this, it is notable that within these hospitals medical doctors practised homeopathy. It is also notable that homeopathy enjoyed support from the Royal Family. In 1948 the London Homeopathic Hospital became the Royal London Homeopathic Hospital. For unorthodox practitioners barred from the NHS there was some comfort to be had from the fact that when it came to it the NHS did not reduce the market for 'private' healthcare to the extent that some had feared.

In the context of the sociology of professions, the establishment of the NHS might be viewed as a victory for the dominant healthcare group, the medical profession, at the expense of its competitors; inclusion within the NHS becoming a means through which 'mainstream' healthcare might be distinguished from its challengers. Green (1985, p. 188) has argued that through the workings of the NHS the state provided a "prop on which professional dominance rested". The situation, however, was more complex than it may first appear. Whilst the founding of the NHS was associated with positive benefits for the profession of medicine, it can also be argued that it had negative implications for its professional status, as medical doctors became accountable to government in ways that they had not been earlier in the century. In *Need and the National Health Service: Economics and Social Choice* (1976, p. 147) Culyer contended that the NHS offered the prospect of controlling the work of doctors and of monitoring their performance. In this manner the state could increase its influence over healthcare at the expense of the autonomy of the medical profession. It might be claimed that by 1960 other healthcare workers within the NHS, such as chiropodists, dietitians, medical laboratory technicians, occupational therapists,

physiotherapists and radiographers, had taken advantage of the new state of affairs, professionalising and gaining state registration through the *Professions Supplementary to Medicine Act* (Act of Parliament, 1960). Yet Larkin (1983, pp. 180-199) has argued that the statutory regulation of these occupations did not diminish medical hegemony. It represented instead an evolution in the medical dominance of healthcare, another stage in the subordination of paramedical groups.

Within the British health freedom movement of the 1940s it was the BCA who represented chiropractic. Whereas various naturopathic and osteopathic groups participated within the JCUPA, chiropractic was represented by only one organisation. The BCA had become, to all intents and purposes, the political voice of chiropractic in Britain, a fact that would prove to be of great significance to chiropractic's ongoing professional development. This is not to say that all others who had called themselves 'chiropractors' in the years before the Second World War disappeared after the War – they did not – but in the post-war years they lacked collective organisation and representation. Individuals such as Albert Tizard, who practised as a 'chiropractor' in Wales from 1938 until 1956, and whose life history has been described by Young (2007), continued to work largely independently (see also: Wilson, 2008).

In the post-war period the BCA came to represent organised chiropractic in Britain, but during the War, and also in the period immediately following it (when restrictions on movement and money transfer still applied), it was extremely hard, if not impossible, for prospective students of chiropractic to travel to the United States to study. Given its problem of numbers, was the BCA to continue its pre-war policy of only accepting into membership those who had studied at a limited number of North American schools, or as with mixing, was it to take a more relaxed stance to chiropractic education in view of its changed circumstances?

In response to the problem of numbers at least two North American trained chiropractors took it upon themselves to instruct apprentices. Russell Llewellyn, a 1929 graduate of the Palmer School of Chiropractic and an ex-President of the BCA, was one. Mary Walker, a 1935 graduate of the same school (British Chiropractors' Association, 1941c), was another. In an article published in the *European Chiropractic Bulletin* in 1947, Llewellyn explained his reasons for taking on apprentices (Llewellyn, 1947, p. 2):

My reason for undertaking the training of two people is not to establish a one man school, for personally I certainly have not the ability to teach the basic sciences so essential to a complete understanding of the Chiropractic Principle. The reason I embarked on what I am doing is briefly

that here in England with an ever growing demand for Chiropractic service we are from month to month faced with an ever dwindling number of Chiropractors to satisfy that demand. Since December of last year we have lost five Chiropractors by emigration and one by death and there is still another one contemplating moving to South Africa. These facts plus the knowledge that the medical profession are gradually accepting, adopting and even teaching our work leads me to the conclusion that desperate needs require desperate deeds.

Llewellyn's contention that demand for chiropractic was growing is notable, but insufficient evidence has come to light to establish beyond doubt that this was in fact the case. Similarly, although there were medical doctors who practised manipulation in Britain during the 1940s, their exact number is not known. What is known is that at St. Thomas' Hospital the tradition of teaching manipulation was continued (Barbor, 1953; Schiötz & Cyriax, 1975, p. 175).

Henri Gillet, the editor of the *Bulletin*, maintained that by taking on apprentices, by taking things into his own hands, Llewellyn had broken the "sacred chiropractic law" (Gillet, 1947, p. 12). Parnell Bradbury, in contrast, was more sympathetic, claiming that Llewellyn was right, and that it was ridiculous that "so much fuss is made over diplomas when the American diplomas are not recognised by the State" (European Chiropractic Bulletin, 1947, p. 3). Bradbury was not a member of the BCA, and he had not studied at a school recognised by the BCA, but he did consider himself a chiropractor (Bradbury, 1957, back cover). Gillet wrote of him that though not a chiropractor himself, in the sense that he had no American diploma, he had at heart the chiropractic cause (European Chiropractic Bulletin, 1947, p. 3).

According to Harding (1997, pp. 123-124), Mary Walker had been interested in setting up a chiropractic school in Britain before the Second World War. She had been a member of the BCA, but it would seem had resigned over a matter of "regulations" (European Chiropractic Bulletin, 1949a, p. 14), possibly because she chose to practise radionics alongside chiropractic (Nind, 2008). In 1947 she accepted Joan Nind as an apprentice, and then in 1948 she took on a second apprentice, John McTimoney. It should be borne in mind that in the twentieth century the idea of 'professional education' was linked to formal schooling and to the university sector (see Wilensky, 1964, pp. 142-144). In Britain medical doctors were not trained through apprenticeship. With respect to professionalisation therefore, the availability of apprenticeships in chiropractic may be seen as a retrograde step.

In 1949 an announcement was made in the *European Chiropractic Bulletin* that a school was to be set up in Oxford with Mary Walker as its Principal (European Chiropractic Bulletin, 1949b). The plan was to commence teaching in September 1949 (Oxford School of

Chiropractic, 1949, p. 5), but the idea met with disapproval from the BCA (European Chiropractic Bulletin, 1949a). In the end Mary Walker decided not to pursue the project. Her school did not open.

As it happened, the BCA had been exploring other means by which chiropractors might be educated in Britain, and in doing so exhibited openness to the possibility of establishing joint educational facilities with naturopaths and osteopaths, something that would have been unthinkable before the War. Following the failure of the BHFS and the JCUPA to gain a place for unorthodox therapies within the NHS, a General Council of Natural Therapeutics (GCNT) was set up to unite and further the interests of disciplines that could be classified under the broad heading of “natural therapeutics” (General Council of Natural Therapeutics, 1950, p. 1). At the first meeting of the General Council, which took place in April 1947, six associations were represented: the Association of Bates Practitioners (whose practice was concerned with improvement of eyesight), the British Chiropractors’ Association, the British Naturopathic Association, the National Institute of Medical Herbalists, the Natural Therapeutics Association, and the Society of Osteopaths. The GCNT sought to safeguard the welfare of its constituent organisations and to gain increased recognition for them within British society. An attempt was made to set minimum standards of education and to ensure a commitment to full-time practice on the part of practitioners. In July 1947 a Joint Conference of the GCNT considered the training of future practitioners in chiropractic, medical herbalism, naturopathy and osteopathy. It discussed a recommendation that five years of training was appropriate for students to attain an adequate level of competence in their chosen discipline (Table 3). In November 1947, however, the Association of Bates Practitioners resigned from the General Council, unable to agree to the suggested five-year training programme, or to the resolution that only full-time practitioners should be allowed to practise. There were also differences of opinion amongst those associated with the BCA. When once again it became possible for prospective students of chiropractic to travel to the United States to study, British students at the Palmer School of Chiropractic wrote to the BCA to voice their concerns about the proposals to link with the other groups (Bennett, 2003). Having investigated the possibility of a joint school, the BCA ultimately came to the conclusion that there was no useful purpose to be served from further discussions (European Chiropractic Bulletin, 1949c). The BCA opted temporarily to maintain its traditional reliance on North American chiropractic schools to generate its membership.

Even though a joint school was not set up, the programme of study that was discussed by the GCNT tells us something of how thinking within chiropractic, and within natural therapeutics as a whole, was changing. The length and content of the proposed programme,

Table 3: Proposed schedule of training for future practitioners of chiropractic, medical herbalism, naturopathy and osteopathy, as submitted to the General Council of Natural Therapeutics on 10th May 1947

Entrance requirements	The attainment of a standard of general education, that is, matriculation or like qualification, as required for entrance to British or Dominion Universities, or the School Leaving Certificate.
First year	Physics; Biology; Chemistry, Inorganic and Organic. Any additional subject or subjects necessary at this period for the proper understanding of the principles and philosophy of the specified therapy in particular.
Second and third years	Human Physiology; Anatomy, Neurology and Histology; Pathology; Dietetics; Hygiene and Prevention of Disease; Mental Disease; Minor Surgery; Diagnosis (clinical, laboratory, microscope and radiological). Any additional subject or subjects necessary at this period for the proper understanding of the principles and philosophy of the specified therapy in particular.
Fourth and fifth years	Paediatrics; Gynaecology; Obstetrics (lectures only); Clinical Instruction and Practice. Any additional subject or subjects necessary for a complete understanding of the specialised therapy in theory and practice.

Source: General Council of Natural Therapeutics (1947)

with inclusion of pathology and diagnosis, mirrored medical education, suggesting forces at work promoting medicalisation within natural therapeutics. As a matter of fact, in a separate initiative to that of the GCNT, osteopaths linked to the British Osteopathic Association established a new osteopathic school in England after the War, the London College of Osteopathy, its object to teach qualified medical doctors the theory and practice of osteopathy through nine months of post-graduate training (London College of Osteopathy, 1947). It is worth remembering that before the War osteopaths had tried repeatedly to achieve statutory recognition, but that on each occasion they had failed, opposed by the medical profession. A lesson to be learnt was that in order to achieve greater acceptance within society, in order to be recognised as professionals, osteopaths, and similarly positioned practitioners such as chiropractors, would have to present themselves in a manner acceptable to those in positions of social authority. In view of the strength of the medical lobby, the opinions of elites within the medical profession could not be ignored. The London

College of Osteopathy was in effect promoting a vision of osteopathy as an ‘add-on’ to medicine, a vision that as it happened was not endorsed by the Osteopathic Association of Great Britain. Chiropractors, particularly those within the BCA, would have to decide whether they wished chiropractic to become an adjunct to medicine, a complementary system, or whether they wished chiropractic to continue to stand apart from medicine.

There were extensive changes to the organisation and technology of British healthcare in the post-war period. The formation of the NHS brought about a major revision to the way that healthcare services were paid for and provided, and during the 1950s and 1960s patients benefited from advances in various medical fields (Porter, 1997, pp. 454-461 & 613-627). Physicians were able to offer an increasing array of pharmacological agents to their patients, surgeons new procedures such as kidney transplants and open heart surgery. In rheumatology the use of cortisone, which became widespread, brought relief to those with inflammatory disorders such as rheumatoid arthritis, and by the 1960s in orthopaedics hip replacement became an option for those with severe osteoarthritis, or other hip joint pathology. Chiropractors found themselves in a changing environment, witnesses to medical progress, but excluded from the NHS. In the field of manual therapy they faced competition from osteopaths, and also from medical doctors and physiotherapists.

In response to their changing circumstances officials within the BCA looked both outwards and inwards. Externally, as has been noted, the BCA exhibited a newfound openness towards working with those of other occupations. Internally, a more tolerant attitude was taken towards mixing. Having accepted that ‘pure’ chiropractic could be combined with other methods of healing, that compromise was possible, the door was opened to the possibility of a realignment of chiropractic with respect to medicine, and to a wider re-evaluation of the place of Palmerian ideas within chiropractic.

In a climate of medical advances grounded in science, and in an increasingly ‘secular’ healthcare environment, a movement developed within chiropractic that encouraged supernatural elements inherent to the traditional Palmerian system of beliefs to be de-emphasised and chiropractic rhetoric to become more ‘materialistic’. It is important to stress that not all chiropractors changed their point of view, many have not to this day, but to a greater or lesser extent change did occur. Neither was the process instantaneous. Its seeds had been sown before the War (Martin, 1994, p. 219). In the 1920s Warde Allen (who practised in Britain, but was not a member of the BCA) had described chiropractic theory in a wholly down to earth manner, in anatomical and physiological terms (Warde Allen, circa 1925). Even so, if one looks at British chiropractic writings of the mid-1940s onwards and

compares them to chiropractic writings of earlier times, especially to the North American writings of the Palmers themselves, they often have a different feel about them. Sometimes there are clear differences. Not infrequently there is less ‘mystique’ to them. Take, for example, Robert Beech’s booklet *Chiropractic and the Nervous System* (circa 1945). Whilst he claimed to attempt to provide a “comprehensive account of chiropractic” (p. 1), Beech (who served as President of the BCA from 1957 until 1960) made no mention of the spiritual Innate Intelligence described by the Palmers in their writings, preferring instead to present a ‘tangible’ basis for the understanding of chiropractic grounded in anatomy and physiology. Similarly, articles published in the *Chiropractic Health Digest*, a periodical that was edited and produced by Beech from 1949 onwards, typically emphasised the ‘materialistic’ foundations of chiropractic thought, rather than metaphysical notions.

As they de-emphasised the supernatural elements of the Palmerian belief system, a significant number of chiropractors also played down claims to chiropractic knowledge grounded in supernatural inspiration and in appeals to the charismatic authority of the Palmers. Where this happened the claims of chiropractors tended to become less bold, and the principles and practices of chiropractic tended to be modified so as to move closer to the prevailing biomedical paradigm. In spite of this, the fact remains that in 1948 the BCA was party to a memorandum produced by the GCNT, sent to the Minister of Health, in which it was claimed that colds were not caught, that they could not be passed on to others, and that one cause was lowered body vitality as a result of nerve interference in the spinal column, brought about by vertebral subluxations and muscular contractions (General Council of Natural Therapeutics, 1948).

Pragmatism played a part in bringing about change within the BCA during the 1940s and 1950s, but there was almost certainly more to it than that. By the 1950s a new generation of chiropractors, trained post-war, were entering the field. They were the product of a different time. Additionally, there is reason to believe that the paradigm of chiropractic was influenced by chiropractic patients. Generally speaking, in Britain during the 1950s the idea of healthcare provided free at the point of access moved from being a novelty to an expectation, and the notion of the National Health Service became embedded into the British psyche. There can be little doubt that plenty of potential chiropractic patients would have thought twice before paying for private chiropractic treatment if a suitable treatment for their condition was freely available from the NHS. Consequently, there was reason for the public to be more sceptical of chiropractic. Where patients benefited from chiropractic treatment they may well have referred family, friends and colleagues, but the patient who did not perceive benefit from their chiropractic experience would have been far less likely to

encourage others to attend the chiropractor. In this way it might be postulated that a process of patient-based selection took place, influenced by the existence of the NHS, but not wholly a product of it, that helped to define the sorts of conditions that chiropractors saw in their practices. Gradually thinking altered. A therapeutic focus on musculoskeletal conditions increasingly became the norm, and it was less frequently claimed that chiropractic offered a panacea. By 1961 chiropractic in Britain and in other parts of Europe had altered to the point where the Norwegian chiropractor Arne Gjocih (1961, p. 6) was able to write:

Concerning chiropractic as a cure for all, it must be assumed that all modern chiropractors do understand their healing art is of a rather limited scope.

To specialise in the treatment of rather few disorders is the tendency today. In this connection one should not underestimate the common sense of the plain people. The man on the street will soon gather facts by experience and make up his mind what kind of treatment is good for his complaints.

In the post-war years the rhetoric of 'science' was used to add authority to chiropractic claims. In the United States Claude Watkins was amongst those who called for chiropractic principles to be re-evaluated along scientifically defensible lines (Watkins, 1948; *Dynamic Chiropractic*, 1986a & 1986b). His call was echoed in Europe (Draux, 1963; *Bulletin of the European Chiropractic Bulletin*, 1963). It is appropriate to point out that even during its early development in the United States chiropractors had claimed chiropractic to be 'scientific'. The titles of two of the earliest books on chiropractic, *The Science of Chiropractic* (Palmer & Palmer, 1906) and *The Science, Art and Philosophy of Chiropractic* (Palmer, 1910), are testament to this. The early scientific claims of chiropractors held marketing value for them, for science had come to represent a kind of 'special learning' that was inclined to increase public faith in those who professed it (Shortt, 1983; Warner, 1995). In this sense, and in terms of professionalisation, scientific rhetoric was important for chiropractic, however it should not be assumed that the use of scientific rhetoric by chiropractors implied a wholly conscious pursuit of professionalisation on their part. The language of science had become ingrained into healthcare as a shared norm to which chiropractors were exposed, and by which they were affected.

Martin (1994) has argued that during the early development of chiropractic in North America the chiropractic understanding of the nature of science was not entirely the same as that of orthodox medicine. He states (p. 210):

For chiropractors, scientific knowledge was not acquired by experimental control of variables in a carefully regulated laboratory environment. Instead they examined and treated thousands of patients and observed them in health and disease. These observations formed the basis of chiropractic science.

To begin with chiropractors were inclined to take an empirical approach to 'science'. Their argument, in effect, was that when it came to value of chiropractic care, the 'proof of the pudding was in the eating'. Whereas the rigour of this approach may be called into question, not least on grounds of chiropractic partiality, even before the Second World War the foundations of chiropractic experimental science were being laid (Martin, 1994, p. 216-222). In the United States Watkins encouraged chiropractors to become acquainted with the attitudes and methods of biomedical science, and though he might have been disappointed by the overall level of uptake by chiropractors, his message did get through to some. In Europe the scientific evolution of chiropractic was led primarily from the continent, where in Belgium Henri Gillet and his colleagues undertook research with the aim of better understanding the chiropractic lesion (Gillet, 1996 & 2007), and in Switzerland Fred Illi set up an Institute for the Study of Statics and Dynamics of the Human Body (Baker, 1985; Gaucher-Peslherbe, 1996). By 1961 Swiss chiropractors were responsible for producing a 'scientific' journal, *The Annals of the Swiss Chiropractors' Association*, which endeavoured to exclude material of a speculative nature.

In moving closer to the biomedical paradigm chiropractic in Britain went from a position where it was an 'alternative' to medicine, to one where, in theory at least, it could develop a synergistic relationship with the medical profession, even becoming a piece of the jigsaw of mainstream healthcare provision. As previously discussed, however, chiropractors were not alone in wishing to be identified with conservative management of neuromusculoskeletal disorders, and they were not alone in the use of manipulation. The domain that many of them would have perceived to be theirs was also claimed by medical doctors, physiotherapists and osteopaths. It must be borne in mind that physiotherapists established a position for themselves within the NHS at its inception. Moreover, in 1960 the *Professions Supplementary to Medicine Act* provided physiotherapists with official recognition by the state that chiropractors and osteopaths did not have. In December 1959 the Duke of Edinburgh, who was favourably inclined towards osteopathy, had enquired of the British Medical Association (BMA) whether osteopaths were to be included under the *Professions Supplementary to Medicine Bill* (Orr, 1959). The BMA's reply was that the Association's attitude towards osteopathy had not changed since 1935. Osteopaths were not to be included (Stevenson, 1959). Had Prince Philip enquired of chiropractic instead of osteopathy, there

can be little doubt that the response would not have been more positive. In spite of the changes underway within chiropractic, the social and professional distance between medicine and chiropractic in Britain remained sizeable.

It is appropriate to conclude this discussion of the paradigm of chiropractic on a cautionary note. In the absence of data from suitably focused surveys of chiropractors undertaken during the 1940s, 1950s or 1960s, it is not possible to know the detailed breakdown of chiropractic opinion in Britain across these years. What is clearer is that a complete paradigm shift did not occur within British chiropractic. As the coming chapters will illustrate, there would be counteraction against medicalisation of chiropractic and against the challenge to chiropractic vitalism. John McTimoney, one of the two students trained by Mary Walker, would become a key protagonist in the reactionary movement. Diversity and complexity would remain features of the chiropractic identity in Britain.

6.3 The Anglo-European College of Chiropractic

A survey by Wilson reported in *The Lancet* of May 1962 sheds light on patients in Britain who used manipulative services at the beginning of the 1960s (Wilson, 1962). In January 1961 the Research Committee of the Northern Home Counties Faculty of the College of General Practitioners sent a questionnaire to its members and associates practising in Essex, Hertfordshire, Bedfordshire and Middlesex, concerning manipulation. Of 290 questionnaires sent out, replies were received from 92, a response rate of 32%. Of these, 15 stated that their patients frequently had manipulative treatment and 68 that their patients occasionally had manipulative treatment, whether from a hospital consultant, physiotherapist, chiropractor, osteopath, or general practitioner (GP). Seventy-five felt that manipulation had a place in orthodox practice, and 38 reported that they manipulated patients themselves. Of those who manipulated patients themselves, only eight had had formal training.

In considering these findings it is appropriate to recognise that only one third of those to whom the questionnaire was sent responded. It is not unlikely that those who took the trouble to respond were those most favourably inclined towards manipulation. On the other hand, it is also appropriate to recognise that patients were not asked to respond themselves and some may not have divulged to their GP that they had consulted an unorthodox practitioner. Taking these factors into account, the figures still suggest significant use of manipulation in treating patients of GPs in the northern Home Counties. They also suggest openness towards use of manipulation on the part of many GPs. From the mid-1960s training courses in manipulation aimed at general practitioners were run by the British

Association of Manipulative Medicine (BAMM), an organisation formed in 1963 (Maxwell Robertson, 1981). BAMM's first Chairperson was Ronald Barbor, who having become interested in orthopaedic medicine whilst working as a general practitioner, had come to be James Cyriax's apprentice and later his partner (British Medical Journal, 1989). BAMM advertised its courses in the *British Medical Journal* (For example: British Medical Journal, 1966, 1967a, 1967b & 1969).

Although Wilson's survey did not specifically consider referral or delegation of care from GPs to chiropractors or to osteopaths, one might assume that this was a rare occurrence, certainly in an official capacity. The General Medical Council advised, as it had done for many years, that any doctor who knowingly enabled or assisted a person not duly qualified and registered as a medical practitioner to practise medicine, or to treat patients in respect of matters requiring medical or surgical direction or skill, would become liable to disciplinary proceedings (General Medical Council, 1963, p. 11). Even transfer of x-rays to a chiropractor or an osteopath had the potential to result in disciplinary action (Storr, 1962; British Medical Association, 1962).

GPs then, one assumes, would not generally have been inclined to send patients for chiropractic care, but what Wilson's survey suggests is that there was a market for manipulation. Disadvantageously however, the membership of the BCA had only grown to 71 by 1962 (British Chiropractors' Association, 1962). If chiropractors were to make large scale inroads into this market they would have to increase in numbers. The political voice of chiropractic in Britain, the only major association of chiropractors that now existed in Britain, the BCA, had always insisted that membership be restricted to those who had graduated from chiropractic schools of which it approved in North America. What was called for was a British chiropractic school recognised by the BCA.

In 1951 the European Chiropractic Union had been re-organised as a union of chiropractic associations, rather than a union of individual members as it had been in earlier years, setting it on what was hoped would be a more secure footing following its near demise after the War (Wilson & Keating, 2007, pp. 24-28). Preliminary discussions to set up a European chiropractic school took place within the ECU in or about 1957 (Bennett, 2003). Britain, France and Switzerland were each considered as locations, but by 1960 definite steps were taken to set up a school in Britain. In that year the Anglo-European College of Chiropractic Limited was registered as a charitable organisation (Anglo-European College of Chiropractic, 1968, p. 7). The proposed school was initially named the Anglo-European College of Chiropractic, rather than as the Anglo-European College of Chiropractic,

because 'chiropractice' was thought to be more 'English'. In 1963 a proposal for a school in Geneva was discussed at a forum in Switzerland (Gillet, 1963), but Swiss chiropractors ultimately supported the British venture. British common law provided the freedom to practise chiropractic without threat of prosecution, a right that did not exist in all European nations, but that would be advantageous to the establishment of a chiropractic school. The determination and actions of key individuals resulted in the creation of a school in this country. Efforts to establish the school in Britain were led by Robert Beech, Donald Bennett and Elizabeth Bennett, who together with others worked to ensure that the vision became a reality.

The magnitude of the task was considerable. Those in favour of setting up the school had to convince sceptical colleagues that the plan was achievable. The financing of the project presented an especially difficult obstacle. Chiropractors were prevailed upon to support the venture through donations and loans. The BCA's link with the ECU was used to promote chiropractic backing from continental nations, a task made easier by the fact that the Anglo-European College of Chiropractice was intended to be a school not just for Britain, but for Europe. A large amount of time and energy went into establishing the scheme's viability. That Robert Beech was President of the BCA from 1957-1960, and that Donald Bennett was President of the BCA from 1962-1965 (British Chiropractic Association, circa 1995), was advantageous.

By 1964 there were sufficient funds and loans secured for a building to be purchased to house the proposed chiropractic school (*Bulletin of the European Chiropractors' Union*, 1964). With prices in London being prohibitively high, premises were purchased in Bournemouth, where Robert Beech had his practice, and by the autumn of 1965 the Anglo-European College of Chiropractice was ready to accept its first students. In October 1965 the *Bulletin of the European Chiropractors' Union* triumphantly announced (*Bulletin of the European Chiropractors' Union*, 1965, p. 1):

The FIRST Chiropractic College outside North America has opened its doors!

After CANADA, EUROPE!

The three B's (Beech, Bennett and Bennett) backed by the big B, the British Chiropractors' Association, backed by some of the European chiropractors, principally by the Swiss, backed by the E.C.U. – have DONE IT!

The founding of the Anglo-European College of Chiropractice stands as a key landmark in the professional development of chiropractic in Britain. The course at the AECC offered a

mechanism through which those residents of Britain who wished to undertake formal study of chiropractic could do so without the need to travel abroad. Not since the 1930s had there been schools purporting to teach chiropractic in Britain, and at no point had there been a chiropractic school recognised by the British Chiropractors' Association. The AECC made access to formal chiropractic education easier for those in Britain. In so doing, it provided a much needed avenue for an increase in chiropractic numbers.

6.4 Conclusions

This chapter demonstrates that chiropractic's professionalisation in Britain was adversely affected by the Second World War, conscription being probably the most important single factor in obstructing its development. After the War chiropractors faced a series of challenges, including a problem of numbers and their exclusion from the National Health Service. The British Chiropractors' Association endured in spite of the challenges that it faced. It became the only major body to represent the interests of chiropractors in Britain.

In the post-war period chiropractic in Britain developed in the way that it did for a variety of reasons. It was affected by external factors beyond its control, and also by internal debates over philosophy and scope of practice. The 1940s were difficult years for chiropractic in Britain, years in which the goal of occupational survival was generally more immediate than that of its professionalisation. The disadvantage of relying on North American chiropractic schools for the training of British chiropractors was highlighted.

In her book on the formative development of modern British general practice, Digby (1999, p. 8-20) employed an evolutionary framework grounded in 'Darwinian' thought. Ideas from evolutionary biology may also be usefully applied to the history of chiropractic.

Fundamental to chiropractic's continued existence in Britain after the Second World War was what evolutionary biologists have termed 'adaptive traits', that is characteristics that facilitated survival and continuation in successive environments (Dobzhansky, 1956, p. 347). Through processes of adaption, chiropractic in Britain was able to sustain itself.

Following the challenges of the 1940s, the 1950s might be seen as a relatively quiet period in the history of British chiropractic, but the 1950s were an important decade from the standpoint of the reshaping of chiropractic principles and practices. Forces had been set in motion that encouraged a change in the paradigm of chiropractic. It is necessary to emphasise, however, that tensions remained within chiropractic. Lack of homogeneity and diversity of opinion lingered within chiropractic. Even so, the 'medicalisation' of

chiropractic that did take place during this phase of its history would prove to be of fundamental importance to its professionalisation. As the paradigm of chiropractic moved towards that of biomedicine, and as chiropractic became less 'alternative' to medical orthodoxy, there was the possibility of a new kind of relationship between chiropractic and the medical profession. The collective action of chiropractors to found an internationally recognised school of chiropractic in Britain was also pivotal to the occupation's professionalisation. Following the death of Bartlett Palmer in 1961, with the opening of the Anglo-European College of Chiropractic, the BCA effectively severed its 'umbilical bond' to North America.

CHAPTER 7

Educational Developments and Political Agitation

Chapter 6 focused on developments in the history of chiropractic in Britain between 1939 and 1965. Key details of particular relevance to the continuance of the thesis include: the establishment of the British Chiropractors' Association as the dominant political voice within British chiropractic; its willingness to consider new alliances and to entertain the biomedical paradigm; and the founding of the Anglo-European College of Chiropractic.

Chapter 7 explores the professional development of chiropractic in Britain in the years following the founding of the AECC. To begin with the AECC had the monopoly on formal chiropractic education in Britain, but this was to be short-lived. In 1972, another school, the Oxfordshire School of Chiropractic, came into existence. With it a new branch of chiropractic, McTimoney chiropractic, began to establish itself. The emergence of McTimoney chiropractic would impart additional complexity to chiropractic in Britain, and would lead to fresh tensions amongst those who called themselves chiropractors.

Having examined key educational developments relevant to the professionalisation of chiropractic in Britain in the years subsequent to 1965, the focus of chapter 7 moves to an examination of chiropractors, their patients, and their place within British healthcare in the early to mid-1970s. The findings of the first detailed survey of chiropractors in Britain, undertaken by Breen in 1973-1974, are considered (Breen, 1976 & 1977).

Discussions then move to focus on political agitation by chiropractors during the 1970s. A crucial moment in the professionalisation of any occupation is that moment when the state provides for its 'social closure' through statutory regulation (Macdonald, 1985). During the 1920s and 1930s chiropractors in Britain had taken defensive actions to protect their interests as osteopaths endeavoured to achieve legal recognition, but it was not until the 1970s that they themselves began earnestly to work towards statutory registration. During the 1970s officials of the BCA applied unsuccessfully to have chiropractic added to the list of occupations governed by the Council for Professions Supplementary to Medicine (CPSM), the CPSM having come into existence following the *Professions Supplementary to Medicine Act of 1960* (Act of Parliament, 1960) to provide for the registration and regulation

of chiropodists, dietitians, medical laboratory technicians, occupational therapists, physiotherapists, radiographers and remedial gymnasts.

7.1 Educational developments

By the end of its first term there were eighteen students studying at the Anglo-European College of Chiropractic: ten from Britain, three from Denmark, three from France, one from Belgium, and one from New Zealand (Bennett, 1965). The programme offered was four years in length and required full-time attendance (Anglo-European College of Chiropractic, 1965). It was modelled on chiropractic courses at North American chiropractic schools, especially that of the Canadian Memorial College of Chiropractic (Bulletin of the European Chiropractors' Union, 1964), a school founded in Toronto in 1945 (Wiese & Peterson, 1995, p. 382).

On successful completion of the programme the student could expect to obtain a diploma conferred by the School, and additionally a 'Doctor of Chiropractic' award in line with chiropractic courses in North America (Anglo-European College of Chiropractic, 1965, pp. 9-10; Anglo-European College of Chiropractic, 1968, p. 15). Neither qualification was officially recognised within the British university system. The 'Doctor of Chiropractic' was not equivalent to a university doctorate. Nonetheless, it had an air of high academic standing about it, and potential to bring to mind a level of educational attainment at least comparable to that necessary to becoming a medical doctor. Many chiropractors chose to use the title 'doctor'.

To a greater or lesser extent, like the programme of study proposed by the General Council of Natural Therapeutics after the War, the curriculum at the AECC was influenced by medicine, with a focus on bacteriology, pathology and diagnosis, as well as on chiropractic principles and techniques (Table 4). Students were expected to develop general diagnostic skills so that they would be able to differentiate patients who might benefit from manipulation from those who might be better served by referral to another practitioner, such as a physician or surgeon. From this it can be ascertained that those who designed the educational programme at the AECC did not view manipulation as a panacea.

If the Anglo-European College of Chiropractic had not come into existence in Britain at the time when it did, it is likely that the subsequent history of chiropractic in the United Kingdom would have been very different. As well as providing an accessible route of entry to chiropractic for inhabitants of the British Isles, it offered a number of other advantages for

Table 4: The curriculum of the Anglo-European College of Chiropractice

First year	Zoology; Physics; Chemistry; Anatomy; Physiology; History of Medicine, Surgery and Chiropractice; Chiropractic Philosophy and Science; Palpation; Manipulative Instruction; First Aid and Emergency Treatment.
Second year	Anatomy; Physiology; Bio-Chemistry; Embryology; Histology; Radiography; Chiropractic Principles and Procedures; Chiropractic Orthopedey; Palpation; Manipulative Instruction.
Third year	Applied Anatomy and Physiology; Bacteriology; Pathology; Radiography; Radiology; Chiropractic Principles and Procedures; Manipulative Instruction; Clinical Practice; Diagnosis and Structural Analysis; Psychology and Psychiatry.
Fourth year	Signs and Symptoms of Clinical Medicine; Bacteriology; Pathology; Radiology; Pediatrics; Gynaecology and Obstetrics (lectures only); Principles and Practice of Chiropractice; Diagnosis and Structural Analysis; Clinical Practice; Comparative Therapeutics; Dietetics; Public Health; Ethics and Jurisprudence; Office Management.

Source: Anglo-European College of Chiropractice (1965)

the professionalisation of chiropractic in Britain. In their efforts to achieve recognition for chiropractic within British society, chiropractors could now point to a school located in Britain, a school recognised within the international chiropractic community, a school which had educational links with the Technical College in Bournemouth (where basic sciences were taught), and at which there were two students in the first cohort in receipt of discretionary county educational awards in support of their learning (Bennett, 1965). As a result of the founding of the AECC, Britain became the primary focus of chiropractic education in Europe, attracting students and revenue from other European countries. Strong links between the AECC and the BCA increased the authority of the BCA at national and at international level.

In spite of the advantages to chiropractic that the AECC provided, from the outset the School faced a number of difficulties and challenges. It lacked direct public funding, having to rely on tuition fees and on the generosity of chiropractors and their supporters to keep it running. It lacked formal recognition by the state and was not part of the university system. Qualifications offered by the AECC were not widely recognised beyond the confines of chiropractic and were not required to practise chiropractic in the UK. Any person who so

wished could quite legally set up in chiropractic practice, call himself or herself a chiropractor, whether they had studied for four years at the AECC, or whether they had had no formal chiropractic training at all.

In the absence of adequate financial backing, the AECC was bereft of a prestigious site and building. It began life in a two storey house in a residential district of Bournemouth, in a building barely fit for purpose, and only able to accommodate a small number of students. Those running the school lacked experience in educational management, and to begin with there was only one full-time chiropractic lecturer, Sidney Cook, an individual who had previously taught at the Palmer School of Chiropractic in the United States (Moss, 2000; Hudson-Cook, 2008). The College Council and Board of Education was made up of chiropractors, none of whom held a higher university degree (Anglo-European College of Chiropractic, 1965). It was difficult to attract non-chiropractic academics to teach at the School because it did not have a sufficiently high profile or positive image, and teaching at the School was not necessarily something that an ambitious academic would want to advertise on his or her curriculum vitae (Bennett, 2003). Although those at the School no doubt did their best to attract high calibre students, a note written in pencil by one of the first students on a copy of an early prospectus is telling. Next to the words "...admission is necessarily selective" the student wrote "Ha Ha" (Anglo-European College of Chiropractic, 1968, p. 9). The minimum entrance requirements for British students wishing admission to the School, as described in the 1965 prospectus, were four passes in General Certificate of Education at 'Ordinary' level, and one at 'Advanced' level, preferably in zoology, but alternatively in physics or chemistry.

The register of the British Chiropractors' Association 1966-1967 listed 53 full members and a further 37 associate members (British Chiropractors' Association, 1966). Of the associate members, nine were non-practising, but were resident in the UK, 28 were resident in other countries. It is not known how many other individuals there were in Britain at the time who described themselves as chiropractors. Those that there were lacked any significant organisational framework through which they might have been affiliated with one another.

With British students studying at the AECC from 1965 the BCA might have expected to see appreciable growth in its numbers from 1969 onwards when the first graduates from the AECC were due to enter the field. In 1966 the AECC purchased a second building to meet the need for additional facilities (Anglo-European College of Chiropractic, 1968, p. 7), however events of 1967 put the future of the AECC in jeopardy. On 12th January 1967 the College Council dismissed Sidney Cook for a variety of perceived shortcomings, and the

student body, which by this time numbered some 34 students (Bennett, 1967a), decided to revolt in support of him (Bennett, 1967b). A meeting of the Student Union on 16th January resulted in a unanimous vote of no confidence in the College Council. Students refused to attend classes and applied pressure on the Council to have Sidney Cook reinstated. Having failed to achieve this, many of them decided to leave the AECC, apply to study chiropractic elsewhere, or pursue other career paths (Moss, 2000). The Chair of the College Council, Donald Bennett, wrote to North American chiropractic colleges informing them of events at the School and asking them not to accept applications for transfer or enrolment from students leaving the AECC without prior consultation with the College. Despite this, a number of North American chiropractic schools did accept students from the AECC. Nine transferred to the Canadian Memorial College of Chiropractic (CMCC) where they were given credit for chiropractic studies undertaken in England. According to Jean Moss (2000), who was one of those who left the AECC to study at the CMCC in 1967 (and who later became President of the CMCC), financial statements from the time suggest that the CMCC was in a precarious financial position itself and that the addition of nine fee paying students had a significant positive financial impact.

Ultimately, only a single student from the first AECC intake, Robert Melvill, successfully completed his studies there, graduating in 1969. Interviewed in 2005, his wife, Gerhild Melvill, stated that one reason Robert Melvill continued his studies at the AECC, rather than moving elsewhere, was that he was the recipient of a Surrey County educational grant (Melvill, 2005). Why Surrey County Council made the decision to provide financial support for Robert Melvill's chiropractic education, when funding was at their discretion, is not clear. It is worth bearing in mind, however, that this decision was made in a political climate that favoured funding and expansion of the higher education sector. In 1962 the *Education Act* had introduced a national mandatory award scheme for those wishing to embark upon first degree university courses (Act of Parliament, 1962), and the 1963 the Robbins Report had called for more places to be made available for those wishing to engage in higher education (Parliamentary Papers, 1963).

Despite the early difficulties, administrators at the AECC were able to maintain sufficient confidence for it to continue to exist and for it to attract new students in subsequent years. This was no insignificant feat given the happenings of 1967. In 1969 the 'e' was dropped from 'chiropractice' in the title of the School, in line with the preferred nomenclature of the BCA, so that the Anglo-European College of Chiropractice became the Anglo-European College of Chiropractic (Bulletin of the European Chiropractic Union, 1969). There were ten

graduates in 1970, twelve in 1971, and eighteen in 1972 (Anglo-European College of Chiropractic, 2000).

In an environment of educational and methodological pluralism in chiropractic, the AECC helped to redefine the parameters of chiropractic education as it related to Britain. In so doing it encouraged chiropractors who were not members of the BCA to consider their position and be more explicit about their differences. It was not long before the AECC had competition in the market for chiropractic education in Britain. In chapter 6 it was stated that Mary Walker, having trained as a chiropractor in the United States, returned to Britain, and that in the years following World War II she accepted Joan Nind and then John McTimoney as chiropractic apprentices. After a period of study each entered practice. John McTimoney developed the ideas that had been taught to him, generated his own particular approach to therapy, and extended care to the treatment of animals (Harding, 1997, pp. 19-27; Andrews & Courtenay, 1999, pp. 21-40). That said, McTimoney believed in 'straight chiropractic' as professed by Daniel David Palmer, that chiropractic analysis and therapy should be undertaken by hand only. During the 1960s he took on his own apprentices and taught them his methods. His students included his son, Russell McTimoney. In 1972 he founded a school, the Oxfordshire School of Chiropractic, in Banbury. One might ask why, when in British context chiropractic was such a small occupation, and when a chiropractic school already existed in Bournemouth, John McTimoney felt the need to establish another one. McTimoney explained his reasons in the following way (Harding, 1997, pp. 19-20):

By the 1920s, the Art had gained so much ground that it was legally recognised in more than one State in the USA. DD Palmer was getting on in years and his son, BJ Palmer, was taking over. Some of the tutors who had been with DD began to disagree with some of the changes BJ was making. They broke away to start their own colleges and thus began the establishment of more than one technique.

More recently new ideas have changed the early chiropractic greatly. One of the biggest dangers is that, in an attempt to gain what they consider to be recognition, some people seem to be prepared to sell the soul of chiropractic and become what I consider quacks, or semi-medical practitioners.

As evidence of this I offer the inclusion in more recent teaching for chiropractic students of the use of X-ray and stethoscopes in arriving at diagnosis. These are methods I consider to be purely medical and not chiropractic at all. Such policy runs the risk of antagonising, instead of persuading the medical profession to place chiropractic in its rightful position as a healing science.

This is the basic history of chiropractic and gives some idea of why it was my intention to teach true chiropractic, which uses only the hands, as the word chiropractic means, and relies upon no other method of diagnosis, nor attempts to be anything but what it is. It respects the medical profession for its own methods and does not attempt to confuse either them or patients, as to the means, claims, diagnosis (or analysis), method, etc., but relies purely upon what Palmer did, namely, to use his hands to cure – hence the term chiropractic.

Chiropractic is the means of restoring health by spinal manipulation and manipulation of other joints.

The aim of the Oxfordshire School of Chiropractic is to train and qualify persons of suitable abilities in the Philosophy and Art of Chiropractic as originated by Daniel D Palmer of Davenport, USA, in 1895 and further developed by John McTimoney, without departing from DD Palmer's ideals.

John McTimoney appears to have believed that it was vital for chiropractic claims to legitimacy to rest on the maintenance of a clear boundary between chiropractic and medicine, rather than on attempts to cross that boundary. Medicalisation of chiropractic was to be avoided. The approach of the AECC in teaching radiography (the taking of x-rays), radiology (the interpretation of x-rays), and use of 'medical' instrumentation (Anglo-European College of Chiropractic, 1968, pp. 32-33), was seen to be flawed.

In addition to the rationale given above there were almost certainly other reasons why John McTimoney felt it appropriate to set up his School. Not having studied at a chiropractic school recognised by the BCA, McTimoney was not eligible for BCA membership. In view of this, there can be little doubt that he would not have felt a strong sense of affinity with the AECC. Moreover, as Harding (1997, p. 19) has pointed out, the course at the AECC did not offer an accessible option for mature students with full-time jobs who wished to study chiropractic. The Oxfordshire School of Chiropractic deliberately focused on attracting mature candidates, offering a three-year part-time course. In the absence of such subjects as bacteriology, pathology, diagnosis, radiography and radiology, the Oxfordshire School of Chiropractic was able to offer a shorter course than the AECC (Table 5). In selecting students for admission McTimoney valued experience of life and personal qualities over academic excellence (Andrews & Courtenay, 1999, p. 30).

The establishment of the Oxfordshire School of Chiropractic had important implications for the professionalisation of chiropractic in Britain. Despite ill-health on the part of its founder, the School produced its first graduates in 1975, adding a dozen new names to the list of

Table 5: The curriculum of the Oxfordshire School of Chiropractic

Subjects were taught across three years, by means of monthly half-day tutorials and approximately twenty hours of directed study per week (50 weeks per year):

Osteology, Myology, Genesiology, Gynaecology, Obstetrics, Paediatrics, Urinalysis, Special Senses, Specific Diseases, Symptomatology, Latin Roots, Philosophy, Syndesmology, Neurology, Orthopaedics, Splanchnology, Angiology, Chemistry, Physiology of Digestion, Endocrinology, Technique.

Sources: Harding (1997, p. 30); Andrews & Courtenay (1999, p. 31)

those who called themselves chiropractors in Britain, but in addition the existence of the School went to emphasise philosophical divisions within chiropractic, muddy waters in the determination of who was and who was not a chiropractor, and restrict the influence of the BCA within British chiropractic. The BCA did not recognise John McTimoney's School. It did not recognise 'McTimoney chiropractic' as a legitimate branch of chiropractic.

7.2 Chiropractors, their patients, and their place within British healthcare

Although the makeup of chiropractic in Britain was to change as a result of John McTimoney's School, in the early to mid-1970s the BCA was the only major association of chiropractors in the UK. A survey by Breen provides a snapshot of the chiropractors that made up the BCA, and of their patients (Breen, 1976 & 1977). Between October 1973 and October 1974 questionnaires were completed by 49 practitioners, representing 72% of the full members of the BCA. Data were taken from the case files of 24 chiropractors, 2,987 individual case files being examined in all. Responses to the practitioner questionnaires painted a picture of a small, largely male group of chiropractors, mostly trained in North America. Their patients were fairly evenly split between males and females, often housewives, or persons from executive or managerial occupations, typically presenting with back pain (53%) and neck pain (21%) of more than three months duration. All of the chiropractors who responded to the survey reported that they had experienced reluctance on the part of patients to inform their general medical practitioner about their chiropractic treatment. Only 6% of chiropractors reported that they often worked in co-operation with GPs, although 74% stated that they sometimes did.

It cannot be known whether Breen's samples were fully representative of the whole population of chiropractors in Britain, or of their patients. Even so, the findings of the study

provide a useful basis for understanding the identity of chiropractic within British society at the time. Even though there was sometimes co-operation between chiropractors and GPs, a significant number of patients were reluctant to tell their general practitioner that they had been to see a chiropractor. Why? Presumably because they considered that their GP might disapprove. No doubt some would have. The General Medical Council discouraged referral or delegation of care to healthcare practitioners such as chiropractors (General Medical Council, 1974, p. 12), and chiropractors worked in private practice, rather than within the NHS. There would have been GPs who were unaware of chiropractic, or did not perceive value in it. That patients typically presented to chiropractors with longstanding complaints suggests that in some cases chiropractic was a last resort for them. That 74% of patients presented to chiropractors with back pain or neck pain suggests that chiropractors had found a niche for themselves in the conservative management of spinal conditions, and that it was with such conditions that patients associated their care.

The results of Breen's survey were published in the journal *Rheumatology and Rehabilitation*. The findings must have been considered of interest to readers of the Journal, but it is not clear how many of those readers were familiar with chiropractic. One medical practitioner who became familiar with chiropractic, and who was impressed by the results of chiropractic that he saw, was Dr Michael Howitt Wilson (my father), a general practitioner from Surrey. He decided to study chiropractic and registered as a student at the AECC in 1974, having been offered a shortened version of the course in view of his medical background. Interviewed in 2008 he was asked what he recalled of the attitude of his medical colleagues when he went to study chiropractic (Howitt Wilson, 2008). He replied that a lot of them thought he had gone mad.

If some medical doctors were less than enamoured of chiropractic, what about other healthcare workers? John Matthews and Ann Moore (now Professor Moore) qualified as physiotherapists in 1970 and 1973 respectively (Matthews, 2008; Moore, 2008). At interview neither recalled being aware of chiropractic at the time of their initial training in physiotherapy, nor immediately after their qualification. Chiropractic lacked a high profile within British healthcare, and where it was known it was not always highly regarded.

Considered in the context of the early to mid-1970s physiotherapy provides a foil to chiropractic, a means of gaining a deeper understanding of chiropractic's place within British society. In terms of gender the two occupations were distinct. There were more male chiropractors than female chiropractors, and the reverse was true within physiotherapy. In relation to professionalisation, of central interest to this thesis, chiropractors practising in

Britain faced issues that contrasted with those of physiotherapists. Where physiotherapists were recognised under law, chiropractors had not achieved statutory regulation; where chiropractors practised with a high level of clinical autonomy, physiotherapists sought autonomy from medicine. It was in 1972 that for the first time the Chair of the Chartered Society of Physiotherapists was a physiotherapist rather than a medical doctor, and in 1974 a by-law of the Society that required physiotherapists to work under the clinical direction of a medical doctor was amended (Barclay, 1994, p. 220). In his writing on professions, Freidson contended that functional autonomy was one of the major variables mediating inter-occupational relations within healthcare (Freidson, 1970, p. 53). The issue of autonomy for physiotherapists in Britain formed the primary focus of a doctoral study by Mercer, completed in 1978. In the conclusion of his thesis he wrote (Mercer, 1978, p. 308):

Throughout the study evidence accumulated that the degree of autonomy was perceptibly increasing year by year, in clinical situations, in management, in professional training. In clinical work, it was found that senior doctors were generally willing to understand, make use of and give greater autonomy to experienced physiotherapists. The therapists on the whole recognised this, accepted it and worked on it. It was the junior doctors who could prove difficult to the therapist who wanted to exercise her expertise within those professional limits possible for her. For this reason most therapists saw it as part of their clinical task to teach or socialise the junior doctor into the ways of physiotherapy. Sometimes this meant pointing out that physiotherapists would do less for a patient than the houseman hoped, more often it meant tactfully conveying to a registrar that the therapist could do more for the patient than he knew or understood. But always the therapist has to be tactful. She is supplementary to medicine. Normally she has to treat after a doctor has made a diagnosis. Many doctors gave a diagnosis and expected and even encouraged the physiotherapist to assess and treat according to her expertise. Sometimes the physio did not want this responsibility. Sometimes the doctor made sure she never had it.

Physiotherapy in Britain had developed largely within the confines of orthodox healthcare, subordinate to the medical profession. Chiropractic, on the other hand, had developed outside the confines of orthodox healthcare, to a significant degree beyond the zone of control of the medical profession. In respect to professional status it might be argued that the relative independence of chiropractors gave them something that physiotherapists did not have, but if that was the case it came at a price. Chiropractors practised outside the NHS, on the periphery of British healthcare.

7.3 Political agitation

Prior to the 1970s the British Chiropractors' Association was not engaged in any significant

direct attempt to achieve statutory regulation for chiropractic in Britain. When Ian Hutchinson joined the Executive of the BCA, in or about 1972, his impression was that it was insular and inward looking (Hutchinson, 2008), but things were about to change. Chiropractors wished to see greater recognition for their occupation within British society, and many of their patients wished to see chiropractic accepted within the NHS. A period of political agitation was about to begin. This marked the start of a crucial phase in chiropractic's professional journey.

In their endeavours the British Chiropractors' Association were supported by a group called the British Pro-Chiropractic Association (BPCA), an organisation of lay advocates set up by grateful chiropractic patients in 1965 to help promote chiropractic (Copland-Griffiths, 1991, p. 218). Although supposedly independent, from its inception the BPCA was allied to the BCA. The names of the two associations being similar and a source of confusion, in 1977 the British Pro-Chiropractic Association changed its name to the Chiropractic Advancement Association (Chiropractic Advancement Association, 1977a & 1977b).

On 26th November 1974 Lord Ferrier of Culter, who had experienced chiropractic treatment himself, and who was supportive of chiropractic, raised concern in the House of Lords that where it seemed that upon request chiropractors provided x-ray records of patients for the NHS, the NHS refused to reciprocate (Hansard, 1974). In response, Lord Wells-Pestell stated that he would not expect NHS doctors to reciprocate, because x-rays were part of the medical record of the patient. If they did they ran the risk of disciplinary proceedings before the General Medical Council for knowingly enabling or assisting a person not duly qualified and registered as a medical practitioner to practise medicine or treat patients. Lord Ferrier asked whether the time had come for chiropractors to be recognised as an integral part of the National Health system, to which Lord Wells-Pestell replied (Hansard, 1974, col. 1233):

My Lords, I think the only reply I can give to the noble Lord is that, under the Professions Supplementary to Medicine Act 1960, the Council for Professions Supplementary to Medicine may recommend to the Privy Council an extension of the Act, and hence for its provision for State registration of additional professions. The British Chiropractors Association could, if they wished, approach the Council in this connection.

Having considered the options at its disposal, and following a vote by the membership, the BCA decided to act. It applied for chiropractors to be included under the provisions of the Council for Professions Supplementary to Medicine. This action had important implications for the dynamics of the relationship between chiropractic and medicine, for the CPSM

governed occupations traditionally considered to be ‘allied’ and ‘ancillary’ to medicine. Ostensibly it suggested that as a body the BCA was prepared to accept a role for chiropractors that was complementary, rather than alternative to medicine. It also suggested that the BCA was prepared to accept a more or less subordinate position for chiropractors relative to their medical counterparts (Bivins, 2007, p. 38; see citation on pp. 6-7).

The BCA’s application was initially considered at a meeting of the CPSM on 23rd June 1975 (Council for Professions Supplementary to Medicine, 1975). A working party was set up, which met on three occasions. Having received the views of the Royal Medical Colleges and other medical bodies, none of which supported the application, the working party reported back to the Council on 2nd February 1976. The Council resolved (Council for Professions Supplementary to Medicine, 1976a, p. 3):

That the application from the British Chiropractors’ Association for extension of the Professions Supplementary to Medicine Act to include the profession of Chiropractic be rejected.

The BCA was informed of the decision through its solicitors, but was not informed of the reasons behind it (Wray, 1976a). Clarification was sought (Harvey, 1976). The Council responded by stating that it was not obliged to give its reasons for refusal of an application. It stated simply that chiropractic could not be regarded as a profession supplementary to medicine under the terms of the *Professions Supplementary to Medicine Act* (Wray, 1976b).

There was a debate on the issue in the House of Lords on 12th May 1976, during which Lord Ferrier suggested that the *Professions Supplementary to Medicine Act* (Act of Parliament, 1960) should be amended to encourage qualification on the part of chiropractors and osteopaths (Hansard, 1976). He asked that what he considered to be the overwhelming powers of the Council for Professions Supplementary to Medicine be reduced. In spite of the actions of solicitors acting on behalf of the BCA, and an appeal to the Privy Council, the CPSM did not change its position and was not forthcoming with details of its reasons for rejecting the BCA’s application (Council for Professions Supplementary to Medicine, 1976b, p. 4; Council for Professions Supplementary to Medicine, 1977, p. 1-2). In a further attempt to put pressure on the CPSM, members of the Chiropractic Advancement Association and of the British Chiropractors’ Association met with officials from the Department of Health and Social Security (DHSS) in June 1978 (Department of Health and Social Security, 1978). Although there was correspondence between the DHSS and the CPSM (Benner, 1978a & 1978b; Donald, 1978a & 1978b), and the BCA was given the option of re-applying to the CPSM if it so wished, without an understanding of the precise

grounds on which its initial application had been rejected the BCA had no mechanism for change. The BCA did not re-apply to the CPSM. In an e-mail dated 25th June 2008, Tom Berrie of the Health Professions Council reflected upon the history of the Council for Professions Supplementary to Medicine. He stated (Berrie, 2008):

In the 1970s medics still dominated all the health professions, and there remained a, largely unspoken, view of the CPSM amongst the professions within it as a sort of 'club' for those that had 'made it'. Getting into the club was therefore almost impossible.

On examining the events surrounding the BCA's application to the CPSM the historian has the advantage of being able to access documents that were once confidential, including CPSM minutes. Unfortunately, however, even the Council minutes do not give detailed insight into the specific reasons for the rejection of the BCA's application. What they do record is that "Members of the Council expressed concern about the scope of practice of chiropractors" (Council for Professions Supplementary to Medicine, 1976a, p. 3). Amongst those who called themselves chiropractors in Britain, and in other parts of the World, diversity of opinion remained as to the range of conditions that chiropractic could successfully treat. Whereas chiropractors employed spinal manipulation for the alleviation of what they thought to be 'mechanical' musculoskeletal conditions, such as common back pain, many of them also continued to lay claim to the successful treatment of 'organic' conditions, such as diabetes and hypertension. This continued to be a source of tension with the medical profession. As a matter of fact, the distinction between chiropractic management of musculoskeletal conditions and chiropractic management of organic conditions formed a central theme of an official examination of chiropractic in New Zealand commissioned by the country's Governor-General, Keith Holyoake, in 1978 (Parliamentary Papers, 1979a, pp. 42-43).

The attempt by the BCA to achieve an extension to the *Professions Supplementary to Medicine Act* represented the most important political endeavour by chiropractors in Britain during the 1970s, but it was not the only attempt by chiropractors and their supporters to gain increased recognition for chiropractic during the decade. In May 1976 a Royal Commission was appointed to consider the best use of financial and manpower resources within the National Health Service (Parliamentary Papers, 1979b, pp. iii-iv; Webster, 2002, p. 74). Both the BCA and the BPCA submitted statements to the Commission calling for use to be made of chiropractic services in cases of musculoskeletal complaints (British Pro-Chiropractic Association, 1977; Parliamentary Papers, 1979b, p. 385), but their calls did not result in policy change. Similarly when the Minister of State for Health, David Owen,

announced the establishment of a Working Group on Back Pain in July 1976, the BCA and the BPCA submitted material in support of chiropractic (Working Group on Back Pain, 1979, p. 26). On this occasion information was also submitted by John McTimoney and by the Oxfordshire School of Chiropractic (Working Group on Back Pain, 1979, p. 27). Once again, however, the calls of chiropractors and their supporters did not result in greater use of their services.

The Chair of the CPSM at the time of the BCA's application for an extension to the *Professions Supplementary to Medicine Act* was Sir Norman Lindop, who, in a twist of fate, became Principal of the British School of Osteopathy in 1982 (Collins, 2005, pp. 312-313). Osteopaths did not themselves formally apply for inclusion under the *Professions Supplementary to Medicine Act*, but in 1976 Joyce Butler MP introduced a Private Member's Bill for the statutory regulation of osteopathy. In the absence of support from the General Council and Register of Osteopaths, who it seems had not been consulted, the Bill failed to become law (Collins, 2005, pp. 285-286).

7.4 Conclusions

This chapter has focused attention on the development of chiropractic in Britain from the mid-1960s until the late-1970s. It has explored educational developments fundamental to the understanding of chiropractic's professionalisation, contemplated chiropractic's social identity, and provided an account of political agitation on the part of chiropractors.

The importance of the Anglo-European College of Chiropractic and of the Oxfordshire School of Chiropractic to the history and professional development of chiropractic in Britain should not be underestimated. These schools would prove to be more long-lasting than earlier 'chiropractic' schools founded in Britain. Through the training that they provided they would change the dynamics of chiropractic. The philosophical differences between them would generate new tensions amongst those who called themselves chiropractors.

Of particular significance to this thesis is the fact that the Anglo-European College of Chiropractic and the Oxfordshire School of Chiropractic came to establish formal chiropractic education as the norm in Britain. As this became the culturally acceptable route of entry into the occupation, so increasingly apprenticeships became a thing of the past. The relationship between 'professions' and formal schooling was highlighted in chapter 6 (see p. 106). Through control of knowledge and education, British chiropractic schools developed occupational influence and authority. They became strategically important 'gatekeepers' of

the occupation. Through certification they offered their graduates ‘symbols’ of authenticity, diplomas that could be used by the chiropractic associations to determine inclusion or exclusion, that is to say as a means of advancing ‘social closure’ (see p.13). Even so, it remained entirely legal for any person to practise ‘chiropractic’ without a formal education.

In the late 1970s chiropractic in Britain was organised, but unorthodox (Breen, 1978). By the end of the decade graduates of the AECC had helped to restore membership of the BCA to pre-World War II levels, but the BCA lacked sufficient authority to markedly influence decision making within the wider healthcare arena. The BCA was unsuccessful in its application to have chiropractic recognised as a profession supplementary to medicine by the CPSM. Chiropractic was treated with suspicion by many within the orthodox medical community. It was excluded from the NHS.

Be that as it may, the campaigning undertaken by the BCA and the BPCA during the 1970s drew attention to chiropractic. It helped to raise its profile within political circles. As such, the political engagement of chiropractors during this period should not be seen as entirely a failure. According to Copland-Griffiths (2008), there were those within the BCA who, prior to its application to the CPSM, expected the request for an extension to the *Professions Supplementary to Medicine Act* to be rejected, and yet they supported it. Why? Their logic was that they believed an unsuccessful application to the CPSM was a necessary step, a step that would provide a platform from which to approach Parliament. Viewed from this perspective the application to the CPSM might be seen to have the objectives of group positioning and signalling intent (see Stojan, 2006). The fact that the application to the CPSM was turned down without reasons being given potentially strengthened the BCA’s position. The BCA was not provided with a mechanism for change. In the absence of such a mechanism, it could be argued that there was little point in it reapplying to the CPSM. It was now a matter for Parliament.

CHAPTER 8

The Path to Statutory Recognition

Prior to the 1980s chiropractic's professionalisation in Britain was primarily 'autonomous', rather than 'heteronomous' in nature (Larson, 1977, p. 67; see p. 11). That is to say, the processes that tended to characterise chiropractic's professional development were generally instigated by the chiropractors themselves, rather than being the design of external social groups. Although the BCA sought to build alliances, for example establishing a partnership with the BPCA, during the 1960s and 1970s chiropractors lacked a sufficient number of influential allies in key political circles to achieve statutory regulation.

Contemporary sociologists, especially neo-Weberians, have often been inclined to view statutory regulation as a defining feature of the profession, and professionalisation as a regulatory strategy that provides occupational groups with an opportunity to increase control over specific areas of work through processes of law (Allsop & Saks, 2002, p. 4; Moran, 2002, p. 19). Following the BCA's application to the CPSM, it became apparent that if chiropractic was to become the subject of statute in Britain, if it was to be regulated under law, chiropractors would have to develop a stronger network of external alliances.

Additionally, the issue of internal heterogeneity warranted attention, for there were forces pulling in different directions within chiropractic. Principles and practices varied between those who called themselves chiropractors. The question of who was and who was not a chiropractor was complicated by the existence of the Oxfordshire School of Chiropractic. In his book *Professions and Power* (1972, p. 53) Johnson associated professionalism with the homogeneous occupational community. In the absence of a unified vision of chiropractic identity, chiropractic's professionalisation was endangered. Occupational boundaries would have to be re-examined and defended. At the very least, if professionalisation was a goal, a public perception of chiropractic homogeneity was to be encouraged.

Chapter 8 examines the pursuit of statutory recognition by chiropractors in Britain subsequent to the BCA's application to the CPSM. It focuses attention on the events and processes that led to the passing of the *Chiropractors Act* in 1994 (Act of Parliament, 1994). The chapter begins by considering chiropractic in the context of complementary and alternative medicine (CAM). Chiropractic's association with CAM provided it with a source

of strength, but at the same time the conspicuously unorthodox nature of many CAM therapies was problematic to chiropractic's professionalisation, for, as I will argue, the concept of the profession and orthodoxy are strongly linked and it is implausible to consider an unorthodox occupation a profession. Through the 1980s and early 1990s those within chiropractic who were in favour of movement towards orthodoxy markedly influenced the direction of developments. As Cant and Sharma (1999, pp. 145-147) have contended, to a greater or lesser extent chiropractors legitimised themselves in the build up to the *Chiropractors Act* through linkage to the established biomedical paradigm. Ultimately, chiropractors of different persuasions and affiliations would work together in the cause of statutory recognition.

8.1 Complementary and alternative medicine

Saks has described the development of non-orthodox healthcare in the second half of the twentieth century in terms of a "counter-culture" in opposition to established medical culture (Saks, 2003a, pp. 94-123; Saks, 2003c). According to Saks this counter-culture was most strongly manifested between the mid-1960s and the mid-1970s, after which conditions became less polarised. Frequently characterised as being natural, humanistic and holistic, unorthodox practices highlighted weaknesses that some perceived in orthodox medicine, and a willingness on the part of patients to exercise consumer choice. There can be little doubt that alternatives to medicine did pose challenges to the medical mainstream, and that even at the start of the 1980s chiropractic in its Palmerian form was thought by many within medicine to be at odds with orthodoxy. The first leading article to be published by the *British Medical Journal* during the 1980s opened as follows (British Medical Journal, 1980, p.1):

Nowadays most GPs – certainly those in the bigger cities – have a few patients who are being treated by alternative medicine: meditation, yoga, acupuncture, moxibustion, ginseng, and a whole galaxy of diets. Elsewhere in the Western World some of these alternative systems have become serious competitors to orthodox medicine. For treating conditions other than bone and joint abnormalities chiropractic, for example (a system of medicine based on the belief that most diseases are due to misalignment of the intravertebral joints) ought to be as extinct as divination of the future by examination of a bird's entrails. Yet instead it is flourishing. In the United States schools of chiropractic attract high quality students and its practitioners are rich – especially now that their patients are eligible for Medicaid. In New Zealand, too, a government commission has recently ruled that patients treated by chiropractors should be eligible for payments through the national health scheme. Here in Britain, chiropractic is very little known; but nevertheless these

decisions in other countries should be cause for concern, since they are further evidence of a trend evident throughout the 1970s – the flight from science.

If this extract is to be believed, chiropractic stood as a prime example of a wider flight from science that had been occurring within western societies. It was an alternative system of healthcare, in competition with medical orthodoxy. Although the passage is clearly hostile towards chiropractic, its message is perhaps more nuanced than it might first appear, for it is notable that the phrasing implies a potential role for chiropractic in the treatment of bone and joint abnormalities, and an apparent acceptance that chiropractic be considered a ‘system of medicine’.

Chiropractic had developed to the point where in 1979 there were an estimated 23,000 chiropractors practising in the United States, and where, in the absence of universal acceptance by medical doctors, chiropractors had nonetheless become a part of the federal healthcare system (McAndrews & McAndrews, 1995, pp. 216-219). In New Zealand chiropractors had won their struggle for inclusion under the provisions of the New Zealand Social Security Act of 1964 and the Accident Compensation Act of 1972 (Parliamentary Papers, 1979a; Hocken, 1980). In certain parts of Europe, notably Denmark (Bak-Jensen, 2007), chiropractic had gained large-scale popular support, and in Switzerland chiropractic was included under mandatory social insurance policies (Mühlemann & Naef, 2007). For all this, there was still a perception that there was something not quite right about chiropractic. Critics contested that some chiropractors continued to rely on ideas that were outdated, intangible and wrong.

Within British society there were those who were critical of chiropractic, but there were also those whose beliefs were more in harmony with chiropractic. In this respect chiropractic’s association with other non-orthodox healthcare practices is important. At the beginning of the 1980s chiropractic was one discipline in a growing field of non-orthodox healthcare occupations and therapies. These occupations and therapies had been variably described in Anglo-American literature by such names as ‘fringe medicine’, ‘unorthodox medicine’ and ‘alternative medicine’. With the passing of time they would increasingly be branded ‘complementary medicine’ and ‘complementary and alternative medicine’ (CAM), a shift suggestive of a changing relationship with the medical profession. They formed a diverse group, yet it would be a mistake to view the professionalisation of chiropractic in isolation from this whole.

In Britain, the Prince of Wales championed the cause of non-orthodox healthcare practices, members of his family, including the Queen, having been advocates of homeopathy for many years. In July 1982 Prince Charles was made President of the British Medical Association for its 150th anniversary year, replacing Sir John Walton (now Lord Walton) in the role (British Medical Journal, 1982, p. 237). At the 150th anniversary Council dinner on 14th December 1982, in a speech entitled 'Complementary Medicine', he described as one of the least attractive traits of professional bodies and institutions the suspicion and hostility which they could exhibit towards the unorthodox or unconventional. He suggested that science had tended to become estranged from nature, and that the whole imposing edifice of modern medicine, for all its breathtaking successes, had become, like the Tower of Pisa, slightly off balance (Charles, H.R.H. Prince of Wales, 1982).

These comments made by Prince Charles in his capacity as the President of the BMA could not be ignored by the medical profession, and indeed the medical profession responded to them. The BMA set up a working party under its Board of Science and Education to consider the feasibility and possible methods of assessing potential value in alternative medicine, but its report, entitled *Alternative Therapy*, cannot have made welcome reading for proponents of non-orthodox healthcare (British Medical Association, 1986). It concluded that assessment would be feasible, in the sense that it would not be totally impossible, but raised a number of concerns. Regarding chiropractic, it stated that this was a system incompatible with scientific knowledge, a system that had to be rejected by anyone who accepted the validity of science (British Medical Association, 1986, p. 35).

The BMA's publication, seen in the light of the sociology of professions, might be viewed as a defensive attempt on the part of a trade union to protect its domain from external challengers. The pronouncement against chiropractic on page 35 of the report was even stronger than that in the first paragraph of the article 'The flight from science' published in the *British Medical Journal* six years earlier (British Medical Journal, 1980, p.1). It might be argued, however, that the BMA had misjudged the changing social climate in relation to unorthodox healthcare. Publication of the report met with a backlash. In Parliament, William Cash MP spoke on the morning of its publication. Having commented on the amount of media attention that the report had received, he criticised it, describing it as "extremely negative, extremely destructive and very ill-timed" (Hansard, 1986, col. 527). He tabled an early-day motion condemning the report, which was signed by about 150 MPs (Hansard, 1987, col. 1380; Hansard 1993, col. 1193).

Writing in the *British Medical Journal*, Anderson and Anderson stated that alternative therapies had “captured the public imagination” and that the BMA’s approach was “closed minded” (Anderson & Anderson, 1986). It did seem that there was marked public interest in non-orthodox healthcare. A survey of nearly 28,000 members of *Which?*, undertaken in February 1986, suggested that one in seven had made use of “complementary medicine” within the previous twelve months (Which?, 1986). A second survey of 1,942 readers, carried out in May 1986, indicated that of those who had visited an unorthodox healthcare practitioner, 81% had tried orthodox medicine for their problem first, but were less than satisfied with it because they had not been cured, because they had seen only temporary relief, or because they could not be treated. Eighty-two percent claimed to have seen improvement in their condition as a result of the non-orthodox therapy received, and 74% stated they would definitely use the same form of therapy again. The practitioners most frequently consulted were osteopaths (42% of responders), homeopaths (26% of responders), acupuncturists (23% of responders), chiropractors (22% of responders), and herbalists (11% of responders). It cannot be known whether the findings of the *Which?* surveys were truly representative of British society as a whole, or whether the results were biased by a high response rate on the part of individuals with positive views on non-orthodox healthcare. Even so, the implication at least, is that a substantial number of people within British society were finding orthodox medicine wanting. Members of the public were looking for alternatives, were prepared to pay for them, and they often liked what they found.

The public mood embraced an openness towards non-orthodox healthcare practices. In addition there also appeared to be openness amongst general medical practitioners in Britain. The results of three surveys of general practitioners published in the *British Medical Journal* (Reilly, 1983; Anderson & Anderson, 1986; Wharton & Lewith, 1986), and a further study published in *The Times* (West & Inglis, 1985), support the idea that an appreciable number of GPs not only viewed non-orthodox therapies positively, but were making use of them. Some were receiving unorthodox treatments themselves; some were sending patients for unorthodox treatments; some had incorporated unorthodox methods into the care they provided for patients. The study by Wharton and Lewith, for example, focused attention on general practitioners in Avon. It considered acupuncture, faith healing, herbal medicine, homeopathy, hypnosis, and spinal manipulation. Two hundred randomly selected general practitioners were sent a questionnaire. One hundred and forty-five responded, of whom 86 (59%) believed that one or more therapy under consideration was useful for their patients. One hundred and thirty-five responders (93%) believed that non-medical practice of these therapies required statutory regulation. In contrast, only four responders (3%) believed that

such practice should be banned. It is notable that the alternative therapy working party of the BMA's Board of Science and Education did not include any general practitioners. Thus, it may not have been entirely representative of the views of the medical profession overall.

Whether a defensive action in response to a perceived challenge to its domain from unorthodox practitioners, or the result of genuine concern about lack of scientific grounding and standards across unorthodox therapies, or a combination of the two, the response of the BMA to the speech by Prince Charles at its 1982 anniversary Council dinner stands in contrast to that of the Royal Society of Medicine. Under the Presidency of Sir James Watt, the Royal Society organised a series of colloquia where orthodox and non-orthodox healthcare practitioners met and exchanged ideas (Watt, 1988). Invitations were extended only to practitioners of certain groups, groups deemed to have adequate educational foundations, an openness to scientific enquiry, and a desire to work towards registration. A distinction was therefore made between the potentially acceptable, and the unacceptable face of non-orthodox healthcare, as seen through the eyes of the Royal Society of Medicine. Representatives from acupuncture, chiropractic, homeopathy, medical herbalism, naturopathy and osteopathy were invited and agreed to take part in the discussions. Eight meetings were held between 1984 and 1987.

Although there appears to have been some mutual mistrust between orthodox and non-orthodox practitioners during the discussions, the colloquia of the Royal Society of Medicine gave rise to inter-occupational debate. They also provided a forum for collaboration between orthodox and non-orthodox practitioners, and between different groups of non-orthodox practitioners.

Viewed as a whole, the 1980s can be seen as a time of increased inter-occupational activity associated with the field of non-orthodox healthcare. Chiropractors engaged in this process. Through the course of the 1980s a series of new inter-disciplinary organisations came into being. In 1983 the Research Council for Complementary Medicine was formed, which undertook and encouraged research. Another organisation established in 1983 was the British Holistic Medical Association, a body which also encouraged research, but concentrated primarily on promoting holistic approaches to healthcare. By the middle of the decade a consensus was forming that an umbrella organisation was needed to promote common standards in education, ethics and discipline amongst non-orthodox healthcare providers. The Council for Complementary and Alternative Medicine was brought into being in February 1985. Its founder members were the British Acupuncture Association and Register, the British Chiropractic Association, the British Naturopathic and Osteopathic

Association, the College of Osteopaths, the National Institute of Medical Herbalists, the Register of Traditional Chinese Medicine, the Society of Homeopaths, and the Traditional Acupuncture Society. During the 1980s universities took an interest in non-orthodox healthcare and research centres were set up at Exeter and Southampton.

In 1989, a MORI Poll suggested that 73% of British residents would seriously consider using unorthodox forms of healthcare, such as acupuncture, chiropractic and homeopathy (Market and Opinion Research International, 1989). Twenty-seven percent reported that they already had. A survey of articles published in the *British Medical Journal* underlines the growing attention to the subject paid by the medical profession (Table 6). Six times as many articles were published about complementary and alternative therapies in the 1980s as in the 1950s, a figure that was set to increase further. The general rise in interest in non-orthodox therapies had positive implications for chiropractic's professional project, not least in raising general awareness of chiropractic within society, but it also drew an association in the mind between chiropractic and methods such as crystal therapy, dowsing, iridology and radionics, an association of which not everyone might approve.

Table 6: Articles relating to 'complementary therapies' and 'chiropractic' published in the *British Medical Journal* between 1950 and 1999

	1950-1959	1960-1969	1970-1979	1980-1989	1990-1999	Total
Number of articles found under the MeSH term 'Complementary therapies'	17	26	88	104	169	404
Number of articles found under the MeSH term 'Chiropractic'	0	0	3	7	16	26

Figures provided are the result of the following queries applied across each time period within PubMed

(Date of search: 27.09.10):

("Complementary therapies"[Mesh]) AND ("British medical journal"[Journal] OR "British medical journal (Clinical research ed.)"[Journal] OR "BMJ (Clinical research ed.)"[Journal])

("Chiropractic"[Mesh]) AND ("British medical journal"[Journal] OR "British medical journal (Clinical research ed.)"[Journal] OR "BMJ (Clinical research ed.)"[Journal])

The foregoing discussions provide evidence in support of the claim that in Britain during the 1980s the medical profession's ability to exercise power was challenged by non-orthodox healthcare practices, but also that during this period the professional distance between the medical profession and some unorthodox healthcare groups decreased. There is, however, an additional context that is worthy of mention, for there were other challenges to the authority of the medical profession that may have influenced its relationship with unorthodox practitioners. From the 1970s onwards Anglo-American sociologists referred increasingly to the 'de-professionalisation' of medicine, that is the loss of its professional qualities; and neo-Marxists to its 'proletarianisation', a change in the status of medical doctors from professionally autonomous practitioners to paid wage labourers (see Haug, 1973; McKinlay & Arches, 1985; Annandale, 1998, pp. 225-230; Rees Jones, 2003, pp. 242-243; see pp. 12-14). Illich (1975) and McKeown (1976) wrote critically of the medical profession, calling for a reappraisal of its role. Armstrong (1976) proposed that the differentiation and development of 'para-medical groups' such as midwives, nurses, pharmacists, physiotherapists and social workers had led to a decline in the strength of medical hegemony in Britain. Elston (1977) wrote of challenges to medical autonomy within the British National Health Service: a questioning of the effectiveness and efficiency of medicine, a questioning of the medical profession's 'right' to control other healthcare workers, and a questioning of the ability of its leadership to successfully represent the interests of doctors. A more recent examination of strains on medical authority can be found in the book *Challenging Medicine* (Gabe, Kelleher & Williams, 1994). The precise extent to which these additional challenges to the medical profession's dominance within healthcare affected its relations with unorthodox healthcare factions cannot be precisely measured, but within the complex web of intra-occupational dealings it is likely that they had a bearing.

8.2 Towards professional maturation

Can a non-orthodox occupation be a profession? Arguably not, for it is in the nature of professions that they conform to what is generally accepted and respected by society at large, holding high status in the social order (Macdonald, 1995, pp. 187-189). That being the case, in order for a non-orthodox occupation to be classified as a profession it must become orthodox, something that, broadly speaking, might be achieved in one of three ways. First, it is possible that through a series of actions a non-orthodox occupation might supersede the prevailing orthodoxy of the day. Second, it is conceivable that events might unfold in such a way that the non-orthodox occupation becomes a concurrent orthodoxy. Third, the non-orthodox occupation might develop such that it conforms to the prevailing orthodoxy,

establishing a place for itself within the confines of an already accepted and overarching paradigm.

Daniel David Palmer's chiropractic and early twentieth century orthodox medicine appear to have been incompatible (see Bivins, 2007, p. 35). One could not reasonably believe that subluxations were 'the' cause of disease and at the same time accept germ theory. As such, chiropractic, in the form advocated by Palmer, offered an 'alternative' to orthodox medicine. It was not intended to complement or supplement the work of orthodox medical practitioners. If the statements made in the preceding paragraph are correct, from an historical perspective, once organised, chiropractors practising in Britain could have taken one of three avenues in pursuit of professionalisation. The first avenue involved challenging the medical profession for supremacy within the healthcare market, superseding the dominant healthcare paradigm, and replacing it with a new orthodoxy. The second avenue involved vying for position within the healthcare arena, with a view to providing a co-existent healthcare orthodoxy alongside the established medical orthodoxy. Neither of these avenues would necessarily have required significant modification to Palmer's system of beliefs, but neither offered an easy road. In fact, given the position of strength held by the medical profession within the British healthcare marketplace of the twentieth century it is difficult to imagine either of these scenarios unfolding successfully from the chiropractic perspective. The route of least resistance, the route most likely to succeed, was probably one in which chiropractors modified their perspectives and activities in order that they became compatible with the pre-existing medical orthodoxy.

In the history of chiropractic there have been individuals and groups who have sought to protect what they have seen as chiropractic's original essence. John McTimoney was one such person. His vision for chiropractic was not one of conformity to the established medical paradigm, but one in which chiropractic was to remain grounded in its own distinct set of principles and approaches (see pp. 124-125). Others, inevitably influenced by their own temporal and cultural backgrounds, have sought change within chiropractic, attempting to make it relevant to a particular worldview and / or acceptable within the confines of prevailing orthodoxy. In the second half of the twentieth century the direction that chiropractic's development took in Britain was strongly influenced by those within the occupation who wished to see its principles and practices remodelled so as to be in harmony with the presiding healthcare orthodoxy. In light of the medical profession's commanding position within healthcare, such an approach, whilst offering potential benefits, would almost certainly require chiropractors to accept a lower standing than medical doctors within the professional hierarchy. As part of the bargain, if one thinks of it in that way, in pursuit of

orthodoxy chiropractors had to de-emphasise traditional metaphysical beliefs and refrain from making grand claims unsubstantiated by science. Chiropractic had to conform to the scientific and educational norms of bio-medicine. In Britain, such a transformation began in an appreciable way in the years after World War II, but gained in momentum during the 1980s. It was a process that as well as requiring adaption to wider cultural expectations, was one of medicalisation.

Viewed from an historical perspective, one means of gauging chiropractic's movement towards medical orthodoxy is to consider the development of its 'scientific culture' in relation to that of medicine. Scientific research, undertaken to understand chiropractic and its therapeutic effects, had been a part of European chiropractic since the 1940s, if not before (see pp. 111-112). In Belgium, during the years of the Second World War, Marcel Gillet had examined the concept of the chiropractic subluxation and had concluded that in its understanding, abnormality of motion was more important than misalignment as traditionally proposed by chiropractors (Gillet, 2007). Marcel and his brother Henri, later joined in their research by Maurice Liekens, had developed 'motion palpation' as a means of assessing the function of joints. In Geneva, during the 1940s, Fred Illi had set up the Institute for the Study of Statics and Dynamics of the Human Body (Baker, 1985; Gaucher-Peslherbe, 1996). Although various periodicals had existed in Britain and in other parts of Europe prior to the 1960s, the first chiropractic periodical to be published in a European country that might credibly have been described as being 'scientific' and 'academic' was published in Switzerland from 1961. The *Annals of the Swiss Chiropractors' Association* were published in English. Contributors came from across Europe, as did the journal's audience, so it might be viewed as a European journal, rather than simply as a Swiss journal. Between 1961 and 1982 it was the only significant European chiropractic scientific journal, but this situation changed in the early 1980s when the European Chiropractors' Union turned its attention to actively encouraging research (Note: A new constitution was ratified by the ECU in 1965, after which the 'European Chiropractic Union' officially became the 'European Chiropractors' Union'. See Wilson & Keating, 2007, pp. 33-35). In 1982, its Golden Jubilee year, the ECU set up a fund in support of those who wished to undertake research relating to chiropractic. Its official publication, the *Bulletin of the European Chiropractors' Union*, was renamed the *European Journal of Chiropractic*, an editorial review board set up, and responsibility for publication delegated to Grant McIntyre Ltd., an associate company of Blackwell Scientific Publications Ltd. (Molloy, 1982a; Molloy, 1982b). The periodical took on a new more scientific air.

The ECU Directory of 1982 listed 769 chiropractors, excluding associate and retired members (European Chiropractors' Union, 1982a). Given the small size of organised chiropractic in Europe, limited resources, and a lack of public funding, advancing the cause of science within European chiropractic presented a difficult task, nonetheless it was recognised that research evidence was of great importance to chiropractic's socio-political development. Arne Christensen (who in 1983 was both Principal of the AECC and President of the ECU), wrote (Christensen, 1983):

Chiropractors are in no doubt as to the value of the service they provide to the community. No chiropractor has been in practice for long, before he or she experiences the dramatic effects that spinal adjustment can have on a person's physiology.

Nobody with a physiological problem, be it a simple musculo-skeletal problem in the low back or a neuromusculo-skeletal problem in the form of aberrant motion in a spinal functioning unit in the lower cervical region causing pain and paraesthesia in the distribution of the ulna nerve, and who has had a chiropractor successfully apply his special skills to the problem, will ever forget the relief chiropractic adjusting can bring to a suffering person.

Individual incidences supported by the opinion of the chiropractors are not enough, however, to change the existing situation in most Western European countries where chiropractic is not recognized by the political system. The politicians who have the responsibility of making decisions also about what type of health care service should be available to the citizens of the individual countries, cannot disregard the existing health care system when they consider how to utilize chiropractic in society. Very often they are faced with having to ask for advice from the people who, at least in the past, have been antagonistic to the whole idea behind chiropractic and the principles of chiropractic, when trying to make decisions on how to incorporate chiropractic care into an already existing health care system.

Where a situation similar to the one described above has developed, the solution adopted by politicians in several countries has been to ask for clinical trials.

Within orthodox healthcare, randomised controlled clinical trials (RCTs) had become the most highly regarded means of assessing therapeutic outcomes, but large scale studies were expensive, and if chiropractors did not wish to leave themselves open to allegations of bias then collaboration with one or more bodies external to the discipline would be advantageous. In this respect chiropractic's professional project and an ideal of scientific research were at odds. On the one hand was the vision that in so far as reasonably achievable scientific research should be unbiased; on the other was the fact that research findings had potential to

help or to hinder the future development of chiropractic. Chiropractors were an interested party.

In Britain, Alan Breen explored possible avenues for setting up an RCT through collaborative means. Interviewed in 2008, he recalled visiting a number of British universities (Breen, 2008). In Wales he spoke with Professor Archie Cochrane about the possibility of arranging a clinical trial under the auspices of the Medical Research Council (MRC). He recalled Cochrane's response to the idea. Pointing to a grape vine, Cochrane asked Breen whether he thought the vine would ever grow grapes. Breen responded that it was too cold and wet to grow grapes where it was, to which Cochrane replied that the chances of the vine growing grapes were about the same as an MRC trial of chiropractic taking place.

Some time later Breen attended a meeting at the Department of Health, where, during the course of a conversation in a lift, Dr Tom Meade's name was brought up as a potentially useful research contact. Meade was Director of the MRC Epidemiology and Medical Care Unit at Northwick Park Hospital, London. Breen approached Meade. In Meade Breen discovered an MRC researcher who was interested in setting up a trial of chiropractic. With the backing of the BCA, and of other organisations, a feasibility study was performed (Working Group, 1986a; Working Group, 1986b), and following the feasibility study an eleven centre study involving 741 patients was undertaken. The focus of investigation was low back pain of mechanical origin, a comparison of management by chiropractors versus hospital outpatient care. Funding was provided by the Medical Research Council, the National Back Pain Association, the European Chiropractors' Union, and the King Edward's Hospital Fund for London.

Meade's study was the first large scale randomised controlled clinical trial of chiropractic undertaken in Britain. Its findings were published in the *British Medical Journal* in 1990 (Meade *et al.*, 1990). The authors concluded that for patients with low back pain in whom manipulation was not contraindicated, chiropractic almost certainly conferred benefit in comparison with hospital outpatient management, and they recommended that introducing chiropractic into the NHS should be considered.

Publication of the study attracted media attention, but it was also the subject of critical academic debate. In the *British Medical Journal* a series of methodological and interpretative issues were raised, amongst them that the study had not compared like with like. It had compared the results of private, unhurried treatment sessions by chiropractors

with care in potentially overcrowded and overworked NHS hospital physiotherapy departments (Graham, Dent & Fairclough, 1990; Edgar, 1990). An article which appeared in the Oxford Medical School Gazette in 1991 stated (Thaler, 1991):

Chiropractic has been vindicated. Or so it would seem. The flurry of press reports that followed the publication of an article in the British Medical Journal was probably the greatest published advertisement the “profession” has ever had. Much less was said in the popular press two weeks later when four full pages of the B.M.J.’s correspondence revealed important flaws in the design, analysis and conclusions of the paper by Meade and his colleagues.

In considering professionalisation, it is all too easy to think of the process as one of mass action and reaction. Often, however, significant events occur as the result of interactions between individuals, sometimes through chance. If not for a conversation in a lift, Meade’s study might not have taken place. Although the study was criticised, its publication drew attention to chiropractic and provided it with new cultural legitimacy. There was an increase in the number of new patients attending chiropractors in Britain in the months following publication of the study (Breen & Langworthy, 1991). Science had shown that it could be a friend to those wishing to promote chiropractic.

Chiropractic’s scientific evolution was paralleled by a co-existing and inter-related educational evolution. By the end of 1979 the Anglo-European College of Chiropractic and the Oxfordshire School of Chiropractic had between them produced in the region of 230 individuals who called themselves chiropractors (Table 7). The vast majority were graduates of the AECC. John McTimoney died in 1980. For a short period his School became known as the John McTimoney School of Pure Chiropractic, before being renamed the McTimoney Chiropractic School (Harding, 1997, pp. 187-188). Under Stan Harding’s leadership the School was reorganised and revitalised.

At the AECC in Bournemouth growth in student numbers meant that by the second half of the 1970s there was little room for further development in the two buildings owned by the School in Cavendish Road. An assessment by the Council for National Academic Awards (CNAA) highlighted the problem. The CNAA was the body responsible for overseeing the degree awarding powers of polytechnics and other non-university institutions, and was asked to advise on the possibility of recognising a chiropractic degree at the AECC (Breen, 2008). According to Breen, having made an inspection of facilities, the key message from the CNAA was a simple one – not in these buildings. New premises were needed. Various options were explored, and in time a successful bid was made for the purchase of Boscombe

Table 7: Graduates of the Anglo-European College of Chiropractic and the McTimoney Chiropractic School, 1969-1994

	1965-1969	1970-1974	1975-1979	1980-1984	1985-1989	1990-1994	Total
Anglo-European College of Chiropractic	2 (2)	73 (75)	144 (219)	172 (391)	294 (685)	438 (1123)	1123
McTimoney Chiropractic School	-	-	13 (13)	40 (53)	110 (163)	99 (262)	262

Cumulative figures are shown in brackets.

Changes in School names: Anglo-European College of Chiropractic, 1965-1969; subsequently Anglo-European College of Chiropractic. Oxfordshire School of Chiropractic, 1972-1981; John McTimoney School of Pure Chiropractic, 1981-1982; subsequently McTimoney Chiropractic School.

Sources: Harding, 1997, pp. 173-182; Personal communication, Anglo-European College of Chiropractic, 2008; Personal communication, McTimoney College of Chiropractic, 2008.

Convent following a merger of local Catholic schools. The purchase was made possible because chiropractors rallied behind the move and helped to provide financial support for it, inspired into action by individuals such as Arne Christensen and George Walker (a chiropractor who would later become President of the BCA). The AECC's new premises were officially opened in 1982 (Anglo-European College of Chiropractic, 1982; European Chiropractors' Union, 1982b).

Buildings can influence an observer's opinion of an organisation. Buildings which are fit for purpose, stylish and expensive looking, situated in a sought after location, can impress. Such buildings are associated with respectability and with professional status (Macdonald, 1989). Although it might be argued that Boscombe was not the most prestigious part of Bournemouth, and that Bournemouth was itself less prestigious than London, the new premises of the AECC were an improvement on what had gone before. The stone construction of the main building, dating from 1888, looked impressive and presented a positive image (Figure 1).

With newly acquired buildings and adequate room for expansion, the undergraduate curriculum and the resources that supported it, including a teaching clinic, were developed. Undergraduate students had always been expected to undertake a research project as part of

Figure 1: The main building of the Anglo-European College of Chiropractic at Boscombe



their studies, but in 1986 a research department was established at the School. Some of the faculty began studying for higher research-based degrees through the University of Southampton.

The changes at the AECC during the 1980s were sufficient that in 1988 the CNAA agreed to validate a Bachelor of Science degree at the School (Nilsson, 1988, p. 53). The AECC became the first school in the field of complementary and alternative healthcare to offer a degree course recognised by the CNAA. In 1990, the AECC's twenty-fifth anniversary year, Diana, Princess of Wales, became its Patron (Christensen, 1990). In 1991 the first graduates with the new degree entered practice.

CNAA recognition of a chiropractic degree marked an important step in chiropractic's professionalisation, but was treated with distrust by some in the medical profession (Minerva, 1988):

The Anglo-European College of Chiropractic in Bournemouth runs a four year, full time

academic course which has now been given degree status. The principal at the college claims in a press release that this "puts chiropractic education on a par with other medical degree courses." Minerva remains sceptical about any quasimedical system that treats disorders exclusively by manipulation without using drugs or surgery.

The claim that chiropractic education was "on a par with other medical degree courses" is striking, and suggests that the Principal of the AECC, Arne Christensen, considered chiropractic to be a form of medicine, a fact pertinent to this thesis. The declaration of equivalence with medical degrees was risky, for it seemed to invite a response from the medical profession. Although it was true that training to become a medical doctor involved study at Bachelors level, in other respects medical education was different. Medical training took place within universities and hospitals, some of which were very prestigious. The AECC, by contrast, was a small independent college that lacked the facilities and public funding of British universities. Its degree was validated by a body whose primary sphere of activity was polytechnics, institutions that on the whole were less highly thought of than the universities.

Developments at the McTimoney Chiropractic School did not match those of the AECC, but as its graduates increased in number so more and more McTimoney Chiropractic became a significant part of the dynamics of chiropractic in Britain. In 1984, Hugh Corley, who had studied under and worked with John McTimoney, formed a breakaway group and set up his own school, at first known as the Witney School of Chiropractic and later as the Oxford College of Chiropractic (Cartlidge, 1997). His followers would become known as 'McTimoney-Corley' chiropractors. Hugh Corley had been one of those who had helped to keep the Oxfordshire School of Chiropractic going during the final period of John McTimoney's life, a time when McTimoney was in a poor state of health. Following John McTimoney's death tensions developed between those in positions of authority at the School. Harding (1997, pp. 129-130) has described Hugh Corley as a person of "excessive confidence", a characteristic that it would appear did not endear him to all. Corley, who had developed his own therapeutic methods, was accused of teaching his own techniques in preference to those of John McTimoney. There was a parting of ways. From 1984 onwards there were three schools in Britain that laid claim to training chiropractors.

On the European continent, another school, the Institut Français de Chiropratique, also opened to students in 1984 (Christensen, 1984). In response to the growing number of schools, the ECU set up an autonomous accrediting body for chiropractic education in Europe, the European Council on Chiropractic Education (ECCE), an organisation modelled

on similar bodies that existed in North America and in Australia. Its Board of Directors gathered for the first time in September 1987 (Kilvaer, 1989). The AECC applied to be accredited by the ECCE and this was granted in 1992. The Institut Français de Chiropratique was accredited in 1995. Neither the McTimoney Chiropractic School, nor the Witney School of Chiropractic, applied for ECCE accreditation during the 1990s.

8.3 Unity in the cause of statutory recognition

Within the medical profession of the 1980s manipulation was practised by a small proportion of doctors. Not many found the time or interest to become good at it. The British Association of Manipulative Medicine continued to attract members, but in 1992 a decision was made to merge it with the Institute of Orthopaedic Medicine, forming the British Institute of Musculoskeletal Medicine. The new body had about 400 members in 1993 (British Medical Journal, 1993). Within physiotherapy manipulation was also a minority interest. The Manipulation Association of Chartered Physiotherapists had existed since the latter part of 1960s and in 1989 it had 450 members (Moore, 1992; Barclay, 1994, p. 293). It represented only one in every one hundred physiotherapists registered with the Chartered Society of Physiotherapy in 1989 (Barclay, 1994, p. 262). Manipulation was used mainly by those working in musculoskeletal physiotherapy. In this respect it is important to recognise that physiotherapy had many therapeutic branches. As well as those who treated musculoskeletal complaints in hospitals and within the community, there were physiotherapists who specialised in areas such as cardio-thoracic rehabilitation, neurological rehabilitation (including care of patients who had suffered strokes), and obstetrics. Many physiotherapists worked within the NHS, some in the private sector. In the private sector, conservative management of musculoskeletal conditions was the remit of physicians, physiotherapists, osteopaths, chiropractors, acupuncturists, and others. No one group had a monopoly. Whereas chiropractors and osteopaths were associated with the use of manipulation, neither could credibly claim it as their own.

In pursuit of legitimacy those within the British Chiropractors' Association had reduced their emphasis on non-scientific claims to knowledge, to a greater or lesser extent accepting and grounding their discipline in the biomedical sciences. On the whole practitioners no longer claimed chiropractic to be a panacea, but concentrated on a more modest scope of practice than their predecessors. Educational standards had been developed so as to increasingly conform to the contemporary cultural norms expected of higher education. Although diversity of opinion and practice remained within chiropractic, a truth that it is important to recognise, these changes, seen in the context of wider socio-political

developments, notably the rise of complementary and alternative therapies in Britain, provided chiropractors with a foundation from which to approach Parliament and seek legal endorsement of their work. A transformation that was not dissimilar had occurred within British osteopathy.

The beginning of the successful parliamentary campaign which culminated in the *Chiropractors Act* of 1994 can be traced back to 1982. In 1982, under the first Presidency of Ian Hutchinson (Hutchinson served a second term as President from 1993 until 1995), a Parliamentary Committee was established within the BCA and a concerted effort begun to convince key figures in Parliament of the value of chiropractic (Hutchinson, 2008). In that year the BCA found itself having to defend its interests at Parliamentary level. A House of Lords Select Committee on the European Communities considered the matter of radiation protection, and the BCA sought to ensure that any future legislation would not interfere with chiropractors' ability to x-ray patients, refer patients for x-rays, or diagnose from x-rays (Hansard, 1982; House of Lords Select Committee on the European Communities, 1982). Alan Breen and Ian Hutchinson gave evidence to the Select Committee on behalf of the BCA. Whereas osteopaths were represented in discussions by the General Council and Register of Osteopaths (GCRO), the Society of Osteopaths, the College of Osteopaths, and the British Naturopathic and Osteopathic Association, the British Chiropractors' Association was the only association of chiropractors directly involved. Organised osteopathy had the benefit of greater numbers over organised chiropractic. In 1982 there were 416 osteopaths listed with the GCRO (Collins, 2005, p. 307). By contrast, the BCA represented 134 chiropractors (European Chiropractors' Union, 1982a). Fewer than two dozen individuals had completed their training at the McTimoney School prior to 1982 (Harding, 1997, pp. 173-174). Although an association of McTimoney practitioners, the John McTimoney Chiropractic Association, had come into existence in 1979 (Harding, 1997, pp. 51-54), it was as yet too small to wield significant political influence. On the matter of x-rays, a tightening of regulations relating to radiological examinations did take place, but chiropractors maintained the legal right to take and use x-rays.

At the beginning of 1984 the British Chiropractors' Association became the British Chiropractic Association when it was registered as a limited company. According to George Walker (Walker, 2010), who was the President of the BCA at the time, the change in name was not intended to reflect a shift in thinking about the role of the BCA. The change did not come about because the BCA had come to see its role as representing chiropractic in Britain *per se*, rather than the interests of its members specifically. Instead it was prompted by widespread use of the word 'chiropractic' in the naming of similar associations

internationally, and because the expression 'British Chiropractic Association' was already being used by some. By becoming a limited company, the officers of the BCA relinquished personal liability for any debts that might be acquired by the Association.

In February 1985, Lord Glenarthur, Parliamentary Under-Secretary of State at the Department of Health and Social Security, outlined the criteria by which chiropractors and osteopaths would be judged in their ongoing efforts to achieve statutory regulation (Hansard, 1985, col. 989):

Demonstrating the efficacy of the therapy is a first essential, but there are other things that a profession must do before it can be given proper recognition. It must show... that it has reached maturity and, for example, has an established and recognised governing body. It must show that the therapy is based upon a systematic body of knowledge, and, while that may not be wholly scientific in character, it must be comparable with the general body of knowledge acknowledged as the basis of contemporary medical practice.

Such a profession must have an accepted working relationship with the organisations of medical practitioners. It must have recognised courses of training which must be generally recognised to be adequate. Examinations must be demonstrably adequate and properly constructed, and should, for instance, make use of external examiners. A profession ought to have an appropriate and acceptable code of conduct, regulating relationships with patients and members of other professions. I believe it would also need to show that the members of the profession were willing to be governed by that code. Fine words in this case are not enough.

The ideas expressed by Lord Glenarthur in 1985 echoed some of those conveyed fifty years earlier by the House of Lords Select Committee that had examined osteopathy (House of Lords Select Committee, 1935; see p. 90 & p. 93). Both highlighted the importance of occupational maturity, compatibility with the ideas of the medical profession, and adequate educational standards. Lord Glenarthur built upon what had gone before, emphasising the need for evidence of therapeutic worth and of ethical practice.

Following Lord Glenarthur's statement, discipline was taken increasingly seriously within the BCA. The Association had produced a code of ethics for members not long after its formation in the 1920s, a code which had been updated over the years, but it was not until the 1980s that details of complaints against members were routinely published in the Association's newsletter. A disciplinary committee dealt with grievances relating to the alleged misconduct of members, and particulars of cases investigated, including the names of chiropractors involved and sanctions imposed, came to be circulated (for example see:

Davidson, 1987; Bennett, 1989). At international level, the BCA sought to strengthen its relationships with other chiropractic groups. In 1987 a chiropractic Presidents' summit was convened in London at the invitation of the European Chiropractors' Union. At the meeting it was proposed that a global alliance of chiropractic associations be formed. A year later, in Sydney, Australia, the World Federation of Chiropractic was officially constituted (Diem, 1989).

An Osteopaths Bill was introduced to the House of Commons by Roy Galley, MP, under the ten-minute rule in July 1986 (Fielding, 1998; Collins, 2005, p. 309). Although it failed to result in law, the action drew attention to the growing political support for osteopathy.

Within British society osteopathy was almost certainly better known than chiropractic, osteopaths being more numerous. The osteopathic cause was championed by royalty. In June 1988 the Prince of Wales held a lunch to which were invited senior members of the medical profession: two Ministers of Health, the President of the General Medical Council, and representatives from the Royal Colleges of Medicine. At the lunch the statutory regulation of osteopathy was discussed and a proposal made for an independent working party to be formed to make recommendations on legislation. Key medical organisations were persuaded to support the vision of osteopathic legislation.

The King Edward's Hospital Fund for London established a working party in 1989, under the Chairmanship of Sir Thomas Bingham. It considered the range and content of possible legislation on osteopathy. Its report, published in 1991, recommended that statutory regulation of osteopathy should ensure protection of title, but not any specific scope of practice, for it was considered difficult, if not impossible, to wholly separate the activities of osteopaths from those performed by others (King Edward's Hospital Fund for London, 1991, pp. 32-33). It recommended that regulation should be separate from Professions Supplementary to Medicine, in view of the fact, amongst other things, that osteopaths worked primarily in the private sector (King Edward's Hospital Fund for London, 1991, pp. 16-17). The osteopathic parliamentary campaign was gaining momentum.

Osteopaths had, to a greater or lesser extent, united in the cause of statutory regulation, and the Department of Health advised that in order for chiropractors to achieve statutory regulation they would have to do the same. Four pre-requisites were outlined (Chiropractic Brief, 1990; Hutchinson, 2008): (1) That all major groups of chiropractors would have to support proposed legislation; (2) That support from the medical profession would be required; (3) That a working party would be needed to make specific recommendations on legislation; (4) That any legislation would have to result from a Private Member's Bill.

Unfortunately for the chiropractors, those who used the title ‘chiropractor’ were far from united. In 1989 the BCA had released a position statement on “McTimoney therapy”. It stated (British Chiropractic Association, 1989):

The British Chiropractic Association has no objection to McTimoney therapists performing their technique. There is likely to be empirical support for the benefits of McTimoney treatment. The chiropractic profession has no desire to hinder them in practising or training followers. What it is concerned about is that the McTimoney profession represents itself to the public, media, and government bodies as a branch of the chiropractic profession when clearly it is not.

This was not the first time that chiropractors had referred to their occupational group as a ‘profession’, indeed Daniel Palmer had described chiropractic as “a new profession” in 1910 (Palmer, 1910, p. 128). Be that as it may, the description is noteworthy, as is its application to McTimoney’s followers. Whereas the BCA contested that McTimoney therapy was not chiropractic, McTimoney practitioners claimed a direct line of descent from chiropractic’s North American roots (The McTimoney Chiropractor, 1989). They felt entitled to describe themselves as chiropractors, and did not view themselves as entirely different from members of the BCA. Although John McTimoney had advocated his own therapeutic techniques, these were grounded in chiropractic methods that had originated earlier, including use of the ‘toggle recoil’ adjustment that had been employed by Bartlett Palmer.

Soon after publication of the BCA’s position statement on “McTimoney therapy” it became apparent that if members of the BCA were to stand a reasonable chance of obtaining legislation for their group, they would have to work with others who called themselves chiropractors. Seeing statutory regulation as a priority, officials of the BCA entered discussions with the McTimoney practitioners.

Not everyone within the BCA was content with this. There was concern about the standard of education at the McTimoney Chiropractic School, and the fact that its training did not require full-time attendance at the School (King S., 1995; Hutchinson, 2008). Not everyone within chiropractic thought that statutory regulation was a good idea. There were those who did not wish to see a change to the status quo, those who were concerned that statutory regulation would reduce the freedom of chiropractors to practise as they saw fit (Copland-Griffiths, 2008; Hutchinson, 2008). In view of these concerns it is fitting to ask how members of the BCA were persuaded to support the initiative. In order to encourage support from chiropractors at grass roots level the potential benefits of legislation were emphasised by elites within the chiropractic associations. An Act of Parliament would, it was argued,

raise the standing of chiropractors and of chiropractic within British society. There was an appeal to the pockets of chiropractors. Chiropractic fees would almost certainly be exempted from value added tax following legislation. Within the BCA the importance of preventing the development of new short courses in ‘chiropractic’ was emphasised. It was claimed that it was necessary to accept McTimoney and McTimoney-Corley practitioners into the fold in order that the door might be closed to others who might choose to describe themselves as chiropractors and then train yet others through inadequate means. The longer the door was left open, the more educational standards were likely to be eroded, and as the number of ‘chiropractors’ outside its ranks grew the less ability the BCA would have to control the situation. Thus it was reasoned that urgent action was required.

In 1991 representatives from three groups of chiropractors came together to form the Chiropractic Registration Steering Group (King Edward’s Hospital Fund for London, 1993). They were the British Chiropractic Association, the Institute of Pure Chiropractic (IPC), representing McTimoney chiropractors, and the British Association of Applied Chiropractic (BAAC), representing McTimoney-Corley chiropractors. Central to the dialogue between the groups were educational standards. It was agreed that within five years of legislation coming into force all groups would be required to have their schools meet an equivalent standard to that required by the European Council on Chiropractic Education on 1st January 1992 (King Edward’s Hospital Fund for London, 1993, p. 1).

Lord Walton of Detchant introduced an Osteopaths Bill to the House of Lords in December 1991 (Fielding, 1998). The Bill had its Second Reading on 31st January 1992, but failed to become law, there being insufficient time for its conclusion before the general election of that year.

Chiropractic followed in the footsteps of osteopathy. Chiropractic factions gave their support to the parliamentary campaign of osteopaths in return for osteopathic support of theirs (Hutchinson, 2008). Osteopaths did not wish to see their efforts towards legislation thwarted by chiropractic protests, and *vice versa*. Osteopaths may also have supported the vision for a Chiropractors Bill in order to prevent ‘dissident’ osteopaths sidestepping the introduction of an osteopathic register by rebadging themselves as chiropractors. Co-operation was seen to be mutually beneficial, but it is appropriate to recognise that this was an alliance of necessity between two occupational groups more naturally in competition with one another. The groundwork of the King’s Fund Working Party on Osteopathy provided a model for a King’s Fund Working Party on Chiropractic, which once again was chaired by Sir Thomas Bingham (King Edward’s Hospital Fund for London, 1993). During the consultations of the

Working Party the Chartered Society of Physiotherapists, who like osteopathic groups were not natural allies of chiropractors, suggested that it would make economic sense to consider amending the Professions Supplementary to Medicine Act (1960) to include chiropractic, rather than working towards a separate Act. This was not what the chiropractors wanted. The BMA expressed the opinion that the idea of a single Bill to cover regulation of both chiropractic and osteopathy was worthy of consideration. Lord Walton, who was a member of the Chiropractic Working Party, and a Past-President of the BMA and of the GMC, at one point supported the idea of a single Bill, but as he became aware of what he perceived to be distinct differences in approach and attitude between chiropractors and osteopaths he came to believe that a single Bill would be unworkable (Walton of Detchant, 2008). The King's Fund Working Party on Chiropractic produced its recommendations for statutory registration and regulation of chiropractic in 1993. In line with the report of the Working Party on Osteopathy, it called for an Act to provide legal protection of the title 'chiropractor', but not to dictate function. It proposed the establishment of a General Chiropractic Council to govern chiropractic in Britain.

Between 1986 when the BMA issued its critique of non-orthodox therapies in the form of the publication *Alternative Therapy* and 1993 when it published *Complementary Medicine: New Approaches to Good Practice*, a change in thinking had occurred. No longer were chiropractors to be disapproved of, instead they were to be considered practitioners with whom medical doctors could reasonably interact (British Medical Association, 1993, p. 6):

Practitioners such as osteopaths and chiropractors, can, for example, treat the mechanical components of a musculoskeletal problem whilst the patient is concurrently taking prescribed medications from the general practitioner, in the form of analgesics, non-steroidal anti-inflammatory drugs (NSAID), or muscle relaxants. In this role, the therapies are an additional and a complementary form of treatment. In the clinical practices of osteopathy and chiropractic, the basic training is largely grounded in the orthodox medical sciences and, as such, practitioners of these disciplines are able to have a close dialogue with their medical colleagues which is based upon a common language. Training modules in these practices increasingly place emphasis on working in conjunction and liaison with established health-care professionals.

Medicalisation of chiropractic education had facilitated co-operation between chiropractors and medical doctors. The advent of General Practitioner Fundholding, introduced by the Conservative Government in 1991, provided an avenue through which selected medical practices could purchase chiropractic and osteopathic services, if they so wished. Some did (Langworthy *et al.*, 2000). Increased interaction between chiropractors and medical doctors

led to increased understanding. The opinions of some medical doctors changed as a result of interactions at practice level. Lord Walton recalled that his image of chiropractic was altered by a visit to the AECC (Walton of Detchant, 2008):

And I saw, for example, the students being taught a neurological examination of which my medical students would reasonably be proud, and I was quite impressed. I also had a talk with a number of members of staff, and in particular Alan Breen, who was doing some physiologically-based research which seemed to me to be of good quality.

In January 1993 Malcolm Moss MP secured second place in a ballot for Private Member's Bills and introduced the Osteopaths Bill to Parliament, which in July 1993 became the *Osteopaths Act* (Act of Parliament, 1993). Then, on 25th November 1993, David Lidington MP secured his place in a ballot for Private Member's Bills. Ian Hutchinson met with David Lidington on 2nd December 1993 and tried to convince him to introduce a chiropractic Bill. This he agreed to do. Interviewed in 2008, David Lidington was asked why he chose to introduce the Chiropractors Bill, rather than a Bill for another cause. He replied (Lidington, 2008):

I decided that I would prefer to do something that was going to give me a footnote in history, rather than something that would get the headlines for a day or two, but which stood no chance of becoming law. I'd taken that decision, in principle. And it seemed to me that this Bill was something that did actually have the power to do a lot of good.

David Lidington's Bill received all party support, and passed unamended through the House of Commons and through the House of Lords. The *Chiropractors Act* received Royal Assent on 5th July 1994 (Act of Parliament, 1994).

8.4 Conclusions

The focus of this chapter has been on the actions and occurrences that paved the way for the passing of the *Chiropractors Act*, an event of fundamental importance to the attainment of professional status in neo-Weberian terms in view of its association with 'social closure' (see p. 13). In the 1970s the BCA had applied unsuccessfully for statutory regulation of chiropractic in Britain through an extension to the *Professions Supplementary to Medicine Act*. Whereas the action of the Association at that time might be viewed as one of political manoeuvring, the BCA's parliamentary campaign of the 1980s and early 1990s was more clearly and specifically directed at the objective of statutory regulation.

During the 1980s and early 1990s the BCA established a network of alliances that made legal recognition of chiropractic in Britain more likely. Parliamentarians had to be convinced that chiropractic legislation was in the public interest, but they also needed to be assured that the medical profession and other key stakeholders, such as osteopaths, were in favour of the action, and that the chiropractic factions could work together. The evolution of CAM, in particular improved relations between some CAM groups and the medical profession, encouraged by the Prince of Wales and by other elites, helped to provide favourable conditions for political agitation by chiropractors. In so far as chiropractors conformed to the norms of scientific medicine and medical education, the epistemological distance between chiropractors and medical doctors tended to decrease. Medicalisation of chiropractic, and the perception of its medicalisation, facilitated appeasement of the medical lobby. Chiropractic in its medicalised form did not pose a significant threat to the dominant position of the medical profession within British healthcare. Neither did it pose an obvious threat to the prevailing medical paradigm. Ultimately, in spite of their differences, chiropractic associations worked together in pursuit of statutory regulation. As the dominant healthcare occupation, the medical profession, came to look favourably on the idea of a chiropractic Act, it became more difficult for other healthcare groups to oppose it. Osteopathic groups supported the proposal of legislation for chiropractic in order to guarantee chiropractic backing for their own legislative campaign. Accordingly, it can be concluded that the *Chiropractors Act* resulted from an elaborate mesh of social interactions and agreements, a mesh that draws attention to the interdependence of health-related occupational groups.

CHAPTER 9

The Chiropractors Act and Protection of Title

Following a successful political campaign, in 1994 chiropractic became the subject of statute in the United Kingdom. The *Chiropractors Act* described chiropractic as a “profession” (Act of Parliament, 1994, sect. 1). Although it lacked the prestige of the profession of medicine, chiropractic had achieved a position of increased cultural legitimacy and respectability. It is important to recognise, however, that the Act did not in itself restrict use of the title ‘chiropractor’ to any specific group or groups within British society, nor did it in itself provide for statutory regulation of chiropractic. Instead, the function of the Act was to legally define the formal mechanisms through which statutory regulation and protection of title could come into effect, but a process of actuation was required.

In chapter 8 events that preceded the *Chiropractors Act* were considered. Chapter 9 starts with an appraisal of the significance of the Act in sociological terms. It goes on to examine chiropractic’s development in Britain between 1994 and 2001, the interval between the passing of the *Chiropractors Act* and the point after which it became a legal offence for any person in Britain to describe himself or herself as a chiropractor without being registered with the General Chiropractic Council.

9.1 The Chiropractors Act: a regulative bargain

The *Chiropractors Act* was intended (Chiropractors Act, 1994, sect. 1):

...to establish a body to be known as the General Chiropractic Council; to provide for the regulation of the chiropractic profession, including the making of provision as to the registration of chiropractors and as to their professional education and conduct; to make provision in connection with the development and promotion of the profession; to amend, and make provision in connection with, the Osteopaths Act 1993; and for connected purposes.

The *Chiropractors Act* and the *Osteopaths Act* (Act of Parliament, 1993) were similar in composition. The design of the *Chiropractors Act* was in essence derived from the *Osteopaths Act*, with aspects of the *Osteopaths Act* fine-tuned by the *Chiropractors Act*. Each Act called for the creation of a specific legally recognised governing body. In the first instance the General Osteopathic Council (GOsC) and the General Chiropractic Council

were to be appointed by the Privy Council (Note: General Osteopathic Council is generally abbreviated to ‘GOsC’ rather than ‘GOC’ so as not to be confused with the General Optical Council). Afterwards registrants would have their say in the election of Council members. Having come into existence, each Council was to establish ancillary committees and appoint a Registrar. It was to be the responsibility of the Registrar to set up and maintain each register. Relevant courses of study were to be assessed in order to determine those qualifications that would be recognised by each Council. Following a period during which experienced ‘osteopaths’ and ‘chiropractors’ might register on the basis of prior safe and competent practice (the consequence of a ‘grandparent clause’ within each Act), applicants would then normally be expected to hold a qualification recognised by the relevant Council.

Registration was also to be dependent upon an appraisal of the character of the applicant, and upon his or her physical and mental health. In these respects the *Chiropractors Act* and the *Osteopaths Act* differed from some previous healthcare legislation (such as the *Medical Act* of 1858), although previous enactments had determined that upon registration nurses had to be of good character and dentists physically and mentally fit for their work (Montgomery, 2003, p. 163). In common with equivalent bodies such as the General Medical Council, the GCC and the GOsC were each obliged to publish a code of ethics in order to direct the activities of registrants.

There can be little doubt that a key consideration in the minds of parliamentarians in the lead up to the *Chiropractors Act* was protection of the public from unskilled practitioners (Hansard, 1994, col. 1170-1172). Chiropractic was seen to have value by many within British society, something which MPs acknowledged, but it was also recognised that in the wrong hands, practised by the unskilled or unethical, it could be dangerous. Under common law anyone could legally call themselves a chiropractor, anyone could practise chiropractic – no training was necessary. The Act was intended to ensure that whilst the public were given access to the benefits of skilled chiropractors, they were also protected from incompetent practitioners and those who would not abide by certain ethical standards.

Legislation was thought to be in the public interest, but in the context of professionalisation it is relevant to consider the extent to which the *Chiropractors Act* benefitted chiropractic and chiropractors. Neo-Weberian approaches to the sociology of professions have emphasised the importance of legislation in providing a means through which ‘social closure’ might be achieved by an occupation (Parkin, 1974; Macdonald, 1995, pp. 27-29; Allsop & Saks, 2002, pp. 4-5). Statutory regulation functions to provide members of an occupational group with legal privilege in the form of a licence to practise in an area of

work, whilst at the same time excluding outsiders from that area of work. The *Chiropractors Act* provided a framework for statutory regulation of chiropractic in Britain. For those considered worthy of registration it offered the potential of a more privileged and prestigious position than before. The title chiropractor would be protected and prospective chiropractors would be required to meet formalised educational standards as a route of entry into the occupation. Taking into account the overlap in the activities of chiropractors and others such as osteopaths, the Act did not define the scope of chiropractic practice, thus allowing for future development of chiropractic along a number of possible paths.

Within chiropractic there were those who viewed the Act as a high point in the occupation's development, an indication that chiropractic had firmly established itself within British healthcare. Others were more sceptical. Graeme Wight judged that the medical profession had supported chiropractic legislation in order to try to control chiropractic through the process of law. He wrote (Wight, 1999):

It is totally naïve to claim that chiropractic, now having an Act of Parliament in place is "established" and "its role in healthcare unquestioned" as was stated by Peter Dixon in the last issue of *Contact*. This is simply untrue.

Whilst the Act offered benefits to individual chiropractors and to chiropractic as a whole, it also constituted a 'regulative bargain' between representatives of chiropractic and representatives of the state (Cooper *et al.*, 1988). It was a bargain that reflected the negotiating power of chiropractors and their allies, a bargain that could not have been negotiated in the presence of highly visible and widespread intra-occupational discord, but as chapter 8 illustrated it was also a bargain dependent upon a wider context. If public opinion had turned against chiropractors during the process of negotiation, if the medical profession had refused to support chiropractors in their endeavour to achieve statutory regulation, if osteopaths had rallied their supporters in opposition to the Chiropractors Bill, or if the Osteopaths Bill had not become law, then chiropractic's regulative bargain with the state would have been less likely. If David Lidington's name had not come up in the ballot for Private Member's Bills held in November 1993, or if he had not agreed to take action for chiropractic subsequent to the ballot, then the Chiropractors Bill might not have been introduced into Parliament. Chiropractic's regulative bargain was reliant upon a jigsaw of elements coming together. Chance played a part in events. In a narrow sense it was an agreement between representatives of chiropractic and representatives of the state, but for that bargain to be made a network of support had to be established, a series of agreements had to be reached, and good fortune was necessary.

In its idealised form the regulative bargain between an aspiring profession and the state is one of trust. The privilege of legally sanctioned self-regulation is bestowed upon the occupation on the understanding that it provides a valued service to society, serving the public interest above other interests. It is assumed that the aspiring profession, comprehending the complexities of its own sphere like no other, will be well placed to regulate itself, and that its practitioners will be likely to abide by standards with which they feel a sense of ownership (Irvine, 2006). In reality, the regulative bargain has tended to be somewhat different from the idealised form. State involvement in the affairs of legally sanctioned occupations has been the norm. The extent of state participation has varied historically, from country to country, and from occupation to occupation. In the case of chiropractic in Britain, chiropractors were obliged to accept a range of conditions as part of their regulative bargain with the state, conditions that will now be considered.

In return for protection of title and other benefits, in line with the regulative bargain in idealised form, it was expected that chiropractors would provide a service to society based on their specific knowledge and expertise. It was expected that they would act in the public interest, prioritising that interest over personal or occupational gain.

Chiropractors would be responsible for providing funds sufficient for the General Chiropractic Council to come into existence and for it to function adequately. Before protection of title could come into effect the GCC had to be financially secure (Copland-Griffiths, 1999). Agreement would have to be reached on minimum standards of education and training in chiropractic, and on standards of safe, competent and ethical practice. Significant intra-occupational disunity on these and other matters would have the potential to kill the process before protection of title came into effect.

The ‘grandparent clause’ in the *Chiropractors Act* would ensure that during the ‘transitional period’ following the Act individuals would be treated as qualified if they could satisfy the Registrar that they had spent a substantial part of five recent years in “lawful, safe and competent practice of chiropractic” (Act of Parliament, 1994, sect. 3). This would allow for members of the major chiropractic associations to register, but it would also leave open the possibility that others might successfully apply for registration. In theory, an individual without formal training in chiropractic, a person who had called himself or herself a chiropractor for a number of years, who had practised safely and competently, but who had acted independently of the chiropractic associations, might successfully register.

In contrast to protection of title, chiropractors had to accept that the Act would not specifically protect the activities associated with chiropractic. Even after protection of title had come into effect, anyone would legally be able to perform techniques identical to those used by chiropractors, provided that they did not claim to be a chiropractor and did not claim to be practising chiropractic. Having said that (and notwithstanding the fact that there were similarities in techniques used by chiropractors and other manual therapists), the particular knowledge and skills associated with chiropractic lay predominantly in the hands of chiropractors. They were not likely to teach their methods to those outside the fold. Thus control of knowledge provided them with a means through which they could endeavour to protect their 'jurisdiction' (Abbott, 1988, pp.19-20) from outsiders.

Control of knowledge, in so far as it existed, increased the command that chiropractors had over their area of work, however under the terms of the *Chiropractors Act* chiropractors would become accountable to Parliament and to the public through the General Chiropractic Council in a way that they had not been previously. Prior to the Act chiropractic had been subject to general law and also to a system of voluntary regulation. Four associations had maintained registers of those who called themselves chiropractors and set standards by which members were expected to abide. They were the British Association for Applied Chiropractic; the British Chiropractic Association; the Institute of Pure Chiropractic, which became the McTimoney Chiropractic Association (MCA) in 1994 (Harding, 1997, p. 103); and the Scottish Chiropractic Association (SCA), a regional group formed by seven members of the BCA in 1979 to represent the interests of chiropractors in Scotland (Bramberg, 1994; Wight, 1994 & 2005). Each association had mechanisms for dealing with complaints from the public, however, whilst recognising a responsibility to patients and to the public, each was an association of chiropractors, concerned with the interests of its members, so that the potential of a conflict of interest existed. The General Chiropractic Council was meant to be a different type of organisation, a governing body for all chiropractors in Britain, which, although functioning to promote chiropractic, was intended to ensure in no uncertain terms that the public interest was upheld.

As previously mentioned, the first General Chiropractic Council was to be appointed by the Privy Council, but subsequent Councils were to be different. Each would consist of twenty members, ten elected by registered chiropractors, six appointed by the Privy Council, three appointed internally by the Council's Education Committee, and one appointed by the Secretary of State (Act of Parliament, 1994, schedule 1). One member had to be a registered medical practitioner, and at least five others were not to be chiropractors, ensuring substantial representation from outside chiropractic on the Council. The requirement for

inclusion of a medical doctor is significant, and draws attention to the fact that the medical profession retained a great deal of influence in the politics of British healthcare. The makeup of the GCC was to be similar to the GOsC, but different from previous legal arrangements with healthcare occupations such as medicine, nursing, and midwifery, where there was less external involvement in the affairs of governance (Montgomery, 2003, p. 163). The activities of the GCC would be overseen by the Privy Council, which would have the right to intervene should it be deemed that the GCC had failed to perform any of its functions adequately (Act of Parliament, 1994, sect. 34). Under common law chiropractors had practised with relative freedom, managing their own affairs. The *Chiropractors Act* would set in motion events that would result in non-chiropractic representation in the regulation of chiropractic in Britain. Paradoxically, the *Chiropractors Act* would be instrumental in limiting and controlling chiropractic self-regulation, and would reduce the authority of chiropractic associations, actions seemingly at odds with professionalisation.

The *Chiropractors Act* stipulated that the GCC publish a code of practice in line with equivalent bodies such as the General Medical Council (Act of Parliament, 1994, sect. 19). In common with the *Osteopaths Act* (Act of Parliament, 1993, sects. 19-20), the *Chiropractors Act* set out the basis for a code that included elements not present in earlier healthcare legislation. There was, for example, specific reference to “professional incompetence” (Act of Parliament, 1994, sect. 20). The GCC was also to be given the authority to require chiropractors to carry professional indemnity insurance (Act of Parliament, 1994, sect. 37). Montgomery (2003, p. 163) has suggested that changes from previous legislation in relation to the code of practice provided evidence of a wish on the part of legislators to protect the public in preference to chiropractors and osteopaths in difficult ethical cases. Whereas this might be seen to imply a distrust of chiropractors and osteopaths in particular, it might also indicate that legislators were generally less trusting of ‘professionals’ than in previous times.

9.2 Attaining protection of title

In respect to science and education, the period immediately following the *Chiropractors Act* was largely a positive one for chiropractic’s professionalisation in Britain. With the expression ‘evidence-based medicine’ fresh on the lips of clinicians, having probably first been employed by Guyatt *et al.* (Evidence-Based Medicine Working Group, 1992), 1994 saw publication of evidence-based national clinical guidelines for early management of low back pain within the NHS, produced by the Clinical Standards Advisory Group (Clinical Standards Advisory Group, 1994). Manipulation, as practised by chiropractors, osteopaths,

and physiotherapists, was recommended as a therapeutic option. A year later, the *British Medical Journal* published results of the extended follow up of the Medical Research Council trial comparing chiropractic to hospital outpatient management for back pain (Meade *et al.* 1990; Meade *et al.*, 1995). The findings favoured chiropractic, and the authors concluded that chiropractic seemed to be more effective than hospital outpatient management. A second set of national guidelines for back pain was published in 1996, this time by the Royal College of General Practitioners (Waddell *et al.*, 1996). Once again, manipulation was advocated as a therapeutic option.

Writing in 1997, Breen contended that evidence-based practice had so far been a friend to chiropractic, in the sense that it had legitimised much of what chiropractors did (Breen, 1997). The *Chiropractors Act* had raised the profile of chiropractic within healthcare. The perception of manipulation as an effective option for back pain encouraged NHS purchasers, particularly those associated with primary care, to contract with chiropractors. Within five years of the *Chiropractors Act* there is evidence to suggest that almost one in five chiropractors provided a service for patients funded by the National Health Service (Langworthy *et al.*, 2000, p. 13). Even so, the proportion of patients able to access chiropractic through the NHS was small. Chiropractic's introduction into the NHS was aided by the General Practice Fundholding Scheme (see pp. 157-158). In 1998 the Labour Government formally abolished Fundholding. Although Webster (2002, pp. 217-218) has argued that in many ways Labour policy constituted a continuation, rather than a rejection of Conservative ideas, following the formal abolition of Fundholding the number of chiropractors providing services financed by the NHS decreased (General Chiropractic Council, 2004b, p. 19). A key reason for this was that the facility for chiropractors to contract directly with individual general medical practices was removed.

In the educational arena, the Anglo-European College of Chiropractic had sought a new authority to validate its degree following decommissioning of the Council for National Academic Awards in 1992. College officials had explored various options, including the possibility of a link with the University of Southampton (Dixon, 1993). It was felt that the University of Southampton offered the prospect of a prestigious relationship, but the proposal for closer ties was ultimately rejected by the University. In time the AECC reached an agreement with the University of Portsmouth. Subsequent to the *Chiropractors Act*, the AECC sought to expand its academic portfolio. In response to a perceived need for formal post-graduate education, in 1996 the College developed a post-graduate MSc. Clinical Chiropractic programme (Humphreys & Bolton, 1998). In 1997 the undergraduate course

was upgraded from Bachelors to Masters level. Both of the new courses were validated by the University of Portsmouth.

The mid-1990s saw significant interest in chiropractic within the newly expanded university sector. A number of universities considered establishing their own chiropractic courses, three of which materialised. In 1997 the University of Glamorgan started a BSc. (Hons) chiropractic degree programme (King & Young, 2002) and the University of Surrey an MSc. Programme (Morley, 1998). In 1998 they were joined by the University of Westminster, which taught McTimoney chiropractic (Andrews & Courtenay, 1999, pp. 39-40).

These developments in the fields of science and education might reasonably be viewed as positive in respect to chiropractic's professional development, but it is important that they are viewed in perspective. Although Breen asserted that evidence-based practice had been a friend to chiropractic, it was in fact the case that strong evidence for the value of manipulation based on randomised controlled clinical trials only existed for back pain.

Evidence for the use of manipulation in other conditions was less substantive. What is more, much of the evidence for the benefit of manipulation as a therapeutic intervention in back pain came from studies that were not of chiropractic. The Medical Research Council trial, whose methodological quality and conclusions had been questioned (see pp. 146-147), was the only large-scale randomised controlled trial of chiropractic that had been undertaken in Britain. Edzard Ernst, who in 1993 became the first Professor of Complementary Medicine to be appointed in Britain, criticised chiropractic. In examining the scientific evidence for and against chiropractic, Ernst, in contrast to Breen, came to the conclusion that it was not clear whether chiropractic did more good than harm (Ernst & Assendelft, 1998). Even for back pain, he argued, the effectiveness of chiropractic had not been proven beyond reasonable doubt. Ernst highlighted potential dangers in chiropractic and asked whether chiropractic was safe. He argued that cervical manipulation, as performed by chiropractors, was associated with a risk of severe adverse reactions, such as stroke (Ernst, 1994); that the use of x-rays by chiropractors appeared to be exorbitantly high, putting patients at increased risk of cancer (Ernst, 1998); and that negative attitudes towards immunisation on the part of some chiropractors were a cause for concern (Ernst, 1995; Ernst 1997). Thus the image of chiropractic as a safe and effective treatment for common musculoskeletal conditions, and of the chiropractor as trustworthy healthcare professional, was challenged.

Although chiropractic was making a transition from private to public sector education, a transition that might be expected of a professionalising occupation (see Wilensky, 1964), two particular features of chiropractic's case warrant attention. First, university-based

chiropractic education in Britain appeared late in the order of the occupation's development, after, rather than before, the *Chiropractors Act*. In contrast, medicine had been taught at the Universities of Oxford and Cambridge for several centuries before the Medical Act of 1858 (Chaplin, 1919; Porter, 1997, pp. 113-118). Second, chiropractic's links to the university sector were made not with 'ancient' or 'red brick' universities, but with newer universities. The study of chiropractic was not associated with the most distinguished of universities.

The *Chiropractors Act* defined the framework for statutory regulation of chiropractic in Britain, but before the legislation could come into effect Commencement Orders had to be issued by the Department of Health. Following the Act, the Department of Health indicated that two key conditions would have to be met by chiropractors before the General Chiropractic Council could be officially sanctioned and the register opened (Copland-Griffiths, 1995a). The first was that whilst recognising the different traditions within chiropractic, chiropractors would be required to show by their actions that they were dedicated to unity. The second was that chiropractors would be required to raise sufficient funds not only for the GCC to function under normal circumstances, but also for it to be able to respond satisfactorily to the potential of appeals from persons who had been refused registration, suspended, or struck off. Before the opening of the register, it was initially estimated that up to £3 million would be required, £1 million of which would have to be available in advance of the GCC coming into being. For a small occupation, organised into distinct associations of which the largest had some 850 members, these demands were not insignificant. It was not a foregone conclusion that the GCC would come into existence.

Were chiropractors dedicated to unity? In public they generally appeared to be. After the Act officials from different chiropractic backgrounds worked together as part of a Transitional Chiropractic Registration Steering Group to prepare for statutory regulation. A Joint Chiropractic Conference took place in January 1995, at which speakers from different chiropractic traditions described their techniques (Back Chat, 1995a). It was agreed between the chiropractic associations that, whereas it was reasonable to promote the benefits of individual branches of chiropractic, it was inappropriate to criticise or make derogatory comments about other branches of the occupation (Background, 1995). Privately, however, tensions remained. Old rivalries did not disappear. Not everyone supported the changes that were happening in chiropractic. Articles and letters appeared in *Contact* and in *Background*, the members' periodicals of the BCA and MCA respectively (periodicals that were not intended for public consumption), that give a sense of underlying disquiet. Within McTimoney chiropractic there were those who were anxious to maintain the spirit of what they saw as the McTimoney approach and its values (Gibbins, 1995; Hanstead, 1998). There

remained concern for the continued existence of McTimoney therapy within chiropractic. Christina Cunliffe (1995) wrote:

Many of us have been quite perturbed by the waves of change caused by the advent of the Chiropractors Act... We have to surf these waves skilfully, or suffer "wipe out".

In spite of calls for unity, some members of the BCA voiced criticism of McTimoney chiropractic. In a letter to *Contact*, Simon King, a former lecturer at the AECC, made known his views (King S., 1995):

It seems to me that the profession of Chiropractic is coming dangerously close to sacrificing its soul on the altar of registration.

My concerns are intensified by the recent notification that the different groups of 'Chiropractors' will be allowed to promote their differences. I accepted an earlier argument that Chiropractors have never practised identical techniques but at least we all started from the same basic educational standards and minimum skill levels.

Now, in the interests of registration, not only are we forced to align ourselves with groups using 1950's Chiropractic philosophy and practising techniques, which would not be recognised as Chiropractic anywhere else in the world, but we have to put up with the promotion of their 'GENTLE' techniques and their 'SAFE' techniques, thereby implying that proper Chiropractic is 'rough' (i.e. painful) or unsafe. Not only will they be able to indirectly denigrate proper Chiropractic (excuse me – what adjective are we supposed to use?) but I notice they also have the audacity to quote the results of the MRC trial in their advertising.

The content of Simon King's letter reflected an undercurrent of opinion within the BCA that was not conducive to intra-occupational harmony, and yet the movement towards establishment of the GCC was not derailed. The reasons for this lie in distinctions between official pronouncements made by associations and unofficial statements made by individuals, in distinctions between private and public proclamations, and in distinctions between words and actions; also in the fact that there was a will on the part of major stakeholders to complete the process that had been started. Official actions in the public domain generally suggested a pan-chiropractic dedication to unity. No concerted effort was made to obstruct the cause of unity. The Department of Health was presented with a public image of chiropractic homogeneity.

By May of 1995 the Department of Health had lowered its estimate for the funding of the GCC to £1.5 million (Copland-Griffiths, 1995b). A Chiropractic Foundation Fund was set up, backed by the Chiropractic Advancement Association (Back Chat, 1995b), donations were encouraged, and chiropractors organised sponsored events in order to raise money (Back Chat, 1995c); but these actions would not be sufficient to raise the capital required. A levy of chiropractors was proposed. At a special general meeting of the BCA in April 1995 a resolution was passed for a supplementary subscription of up to £500 from each member, dependent upon their year of graduation as a chiropractor. The BAAC, the MCA, and the SCA remained to be persuaded. Interviewed in May 2008, Michael Copland-Griffiths, the Chair of the Transitional Registration Steering Group, outlined his approach to gaining the support of two key members of the McTimoney and McTimoney-Corley groups (Copland-Griffiths, 2008):

I said to her [Shelagh James-Hudson of the McTimoney-Corley group], “It looks pretty clear now that the McTimoneys are coming on board with their levy. What are you going to do about it? Are you going to stay out in the cold?” And she said, “Oh no...” So then I went to Dana Green [of the McTimoney group] and said, “Shelagh is going to pay... What are McTimoney doing? You can’t be left out in the cold like this...” That was very naughty I’m afraid, very, very naughty indeed – but it worked.

Following the lead of the BCA, the plan for supplementary subscriptions was agreed by the BAAC, the MCA, and the SCA. At the time there was a genuine sense amongst chiropractors in Britain that this was the right thing to do. Other reasons for support included the promise that value-added tax would no longer be applied to chiropractic fees following statutory regulation, the authority and persuasiveness of occupational elites, and the bandwagon effect.

As funds were raised, the Department of Health took matters forward. In January 1997 a General Chiropractic Council Designate was announced (Contact, 1997a). On 13th August 1998 the Commencement Order was signed that officially brought the GCC into existence (Statutory Instrument, 1998).

Although the target figure of £1.5 million was not reached, the Department of Health remained supportive. Ultimately, members of the BCA contributed £208,500 to the establishment fund, members of the MCA £79,500, the BAAC £16,527, and the SCA £10,022 (General Chiropractic Council, 1999). With £23,450 of contributions made to the Chiropractic Foundation Fund, in all a total of £337,999 was raised. The contributions of the

associations were not in proportion to membership size. Members of the BCA contributed approximately £277 *per capita*; members of the MCA approximately £208 *per capita*; members of the BAAC approximately £119 *per capita*; and members of the SCA approximately £70 *per capita* (based on the number of full and semi-active members of the chiropractic associations in 1999. See: Wilson, 2000, p. 37c). Even taking other factors into consideration, such as practitioner income and time in practice, and the fact that a few chiropractors belonged to more than one association but may have contributed only once, there remains the implication that members of the larger chiropractic associations may have been more committed to the process of establishing the GCC than those of the smaller ones.

Between August 1998 and May 2001 a series of five statutory instruments were published in order to commence elements of the *Chiropractors Act* (Statutory Instrument, 1998; Statutory Instrument, 1999a; Statutory Instrument, 1999b; Statutory Instrument, 2000; Statutory Instrument, 2001). The statutory register opened on 15th June 1999. Two years later, on 15th June 2001, it became a criminal offence for anyone in the UK not registered with the GCC to call themselves a chiropractor. Nearly 1,800 applications for registration were received by the GCC during the 'transitional period' (Morris, 2001). This number included the vast majority of those who were members of the chiropractic associations. There were some who chose not to apply, a few because they were nearing retirement age, but others for practical and / or philosophical reasons. James Wilson (my brother), a 1995 graduate of the McTimoney Chiropractic School, was deterred from applying for registration first and foremost because of the ongoing cost involved (the annual registration fee being £1,000 for a practising chiropractor), in view of the fact that he worked part-time as a chiropractor, and primarily as a computer programmer (Wilson, 2001).

Establishment of the General Chiropractic Council necessitated an organisational restructuring of chiropractic in Britain. Following announcement of the GCC Designate, the Transitional Chiropractic Registration Group was replaced by a Joint Chiropractic Committee, with the intention of maintaining communications between the voluntary chiropractic associations (Contact, 1997b); the Chiropractic Advancement Association, having supported the successful effort to achieve legislation for chiropractic in Britain, changed its name to the Chiropractic Patients' Association (Contact, 1997c); and a new body, initially known as the British College of Chiropractic, came into being (Contact, 1997d; Jay & Atkinson, 1997).

The British College of Chiropractic had its origins within the British Chiropractic Association. As part of the endeavour to develop the field of post-graduate education in

chiropractic following the Act, the BCA's Board of Education organised regional post-graduate education seminars and produced a series of educational supplements to *Contact*. From September 1997 the educational supplements were replaced by a journal, the *British Journal of Chiropractic*, published by the Steering Committee for the British College of Chiropractic, into which the BCA's Board of Education was to be absorbed. Involvement of the BAAC, the MCA and the SCA was sought, with the aim of providing an organisational framework that would be widely accepted by those within British chiropractic. Although at first there was scepticism within the MCA (Cunliffe, 1998), the formation of the College came to be welcomed by the leaders of all four major chiropractic associations (Cunliffe, 1999; Dixon, 1999; Hudson, 1999; Shearer, 1999). The College of Chiropractors, as it then became known, was officially launched in April 1999 (*Contact*, 1999a). Membership was extended to all chiropractors in Britain. Modelled on royal and national professional colleges, such as the Royal College of General Practitioners, the College aimed to facilitate post-graduate education and training in chiropractic, promote chiropractic research, and enhance the status and prestige of chiropractic. Its emergence provides evidence of a continuing professional project by chiropractors, wherein the organisational structures of the medical profession were imitated in the cause of occupational advancement.

Although the restructuring of chiropractic in Britain following the *Chiropractors Act* offered opportunities for chiropractic's professionalisation, it also presented a challenge to the voluntary chiropractic associations that had in significant part been responsible for encouraging it to come about, for there appears to have been an assumption within the Department of Health that following the opening of the chiropractic register the GCC would take over the functions of the voluntary associations of chiropractors, thus making them obsolete (Hutchinson, 2008). In a speech to announce the formation of the General Chiropractic Council Designate in January 1997, the Junior Health Minister, Baroness Cumberlege, stated (*Contact*, 1997a):

The chiropractic profession has devoted a huge amount of time and effort to reaching this point. The existing voluntary bodies must now continue to give the same level of commitment to the GCC during its formative years. We expect that they will continue to function while the new Council prepares to take over control of the profession, and until the statutory register opens.

It was true that the General Chiropractic Council was intended to regulate chiropractic in Britain, a function that had previously been performed by voluntary chiropractic associations. Furthermore, the GCC was designed to develop and promote chiropractic, functions that had also provided the voluntary associations with reasons for being. Yet was it

realistic to expect the chiropractic associations to cease to exist? In attempting to answer this question it is worth bearing in mind that historically establishment of the General Medical Council had not led to the disbanding of the British Medical Association, that establishment of the General Dental Council had not led to the disbanding of the British Dental Association, and that the Chartered Society of Physiotherapy had continued to exist even after the creation of the Council for Professions Supplementary to Medicine. Whereas the General Chiropractic Council was intended to regulate chiropractic in Britain, and whereas it was intended to develop and promote chiropractic, it was obliged to serve the public interest above other interests. As such, it could not function as a trade union, and it could not be guaranteed to protect the interests of the different chiropractic factions. Therein lay the principal case for the continued existence of voluntary chiropractic associations.

As it happened, the voluntary associations had no intention of disbanding following the opening of the register. In common with other voluntary chiropractic associations, the BCA responded to the threat to its existence by rebranding itself, emphasising its role as a trade union (Sandstrøm, 1998). Whereas the GCC was the statutory body for chiropractic in Britain, the BCA continued to protect and further the interests of its members, offering a package of services to chiropractors that included indemnity insurance, legal advice, access to conferences, a journal (*Contact*) and monthly newsletter (*In Touch*), business guidance and corporate advertising (Contact, 1999b).

Divisions within British chiropractic did not disappear after the opening of the register. Arguably, they became more complex as the strands of chiropractic entwined. My own survey of members of the BAAC, the BCA, the MCA, and the SCA, undertaken at the beginning of 2000, drew attention to intra-occupational diversity (Wilson, 2000; Wilson, 2003a). It highlighted significant differences in diagnostic and management approaches, and in the views of chiropractors. Although medicalisation of chiropractic in Britain did not cease following the *Chiropractors Act*, there were those within chiropractic who favoured different approaches. Counter-currents of opinion existed within the chiropractic associations on issues such as scope of practice and chiropractic vitalism. Where some raised concern about what they saw as the proliferation of clinical myths (Byfield, King & McCarthy, 1999), others encouraged a resurgence in more traditional chiropractic beliefs (for example, Whitaker, 1999). Opposition to medicalisation of chiropractic gathered strength. During 2000 a new voluntary association, the United Chiropractic Association (UCA), was formed. Traditional chiropractic principles that had been played down within the BCA were given prominence within the UCA, harkening back to the vision of Daniel Palmer's chiropractic. The core values of the UCA were expressed as follows (Lewis, 2000):

1. We recognise and respect a universal intelligence in all matter and an innate intelligence within a living organism that drives to preserve life and, if left uninhibited, will express optimal potential.
2. The nervous system has a central role in regulating, co-ordinating and integrating the functions of the entire organism.
3. We recognise that interference in innate intelligence (Subluxation) diminishes healing capacity, with an alteration in the dynamic relationship between mental, physical and social aspects of the whole person.
4. The art of chiropractic encourages optimal expression of health by the detection, removal (Adjustment) and prevention of nervous interference.
5. To use drugless, minimally invasive techniques to adjust identified subluxations throughout an individual's lifetime.
6. We commit to assist the process of self-empowerment with compassion and care, whilst respecting each person's dignity, uniqueness and freedom of choice.

Chiropractic in Britain was going through a phase of striking change, complicated by its internal dynamics. During 2000 the GCC considered the courses offered by chiropractic colleges and universities in the UK. It accredited (with certain conditions) courses at the Anglo-European College of Chiropractic, the McTimoney College of Chiropractic (formerly the McTimoney Chiropractic School, where a new BSc. Chiropractic programme validated by the University of Wales was being taught), the University of Glamorgan, and the University of Surrey. Perceiving shortcomings in educational quality, the GCC declined to accredit courses at the Oxford College of Chiropractic (which since 1998 had offered a BSc. Hons. programme validated by Oxford Brookes University), and the University of Westminster. These institutions lost the legal right to train chiropractors. With closure of the Oxford College of Chiropractic, there was no longer a route for prospective McTimoney-Corley chiropractors to be trained. With the cessation of the chiropractic course at the University of Westminster, only one entry route for prospective students of McTimoney chiropractic remained.

There were mixed emotions within chiropractic ranks when the 'transitional period' ended and protection of title came into effect. In an editorial for *Background*, published in the

summer of 2001, Christina Cunliffe, Principal of the McTimoney College of Chiropractic, wrote (Cunliffe, 2001):

I usually try to write an upbeat editorial, regardless of how I am feeling or what else is going on, but this time I feel the need to acknowledge the reality of what we have been through during the registration process. For some of you there is no question that this has been the worst of times. A time that has called into question the very essence of what we do; that has precipitated early retirement for some, or forced a choice to walk a different path and relinquish the right to all that they trained to be – a chiropractor. Others have struggled with their conscience, but have decided to join the Register despite grave misgivings.

9.3 Conclusions

The discussions of preceding pages have concentrated on analysis of the *Chiropractors Act* and on the history of chiropractic's journey from the Act to protection of the title 'chiropractor' under British law. In respect to professionalisation, the realization of protection of title represented fulfilment of chiropractic's regulative bargain with the state. For prospective patients of chiropractors it provided a defence against incompetent or failing practitioners, since only those registered with the General Chiropractic Council could lawfully describe themselves as 'chiropractors'. For those registered with the GCC, it brought official sanction and enhanced prestige.

Britain joined other European nations in which chiropractic was expressly regulated under law – Cyprus, Denmark, Finland, Iceland, Liechtenstein, Norway, Sweden and Switzerland (Chapman-Smith, 2000, p. 30). In the rest of Europe the situation was generally less positive for chiropractors. In Germany chiropractors practised lawfully as *Heilpraktiker*, that is as lay healing practitioners (Ernst, 2001; White, 2007); in Ireland, as had previously been the case in Britain, chiropractors practised legitimately under common law; but in a number of other European countries the threat of legal prosecution hung over those who practised chiropractic without being medically qualified, for instance in France, Italy and Spain (Rouy, 2007; Rigel, 2007; Heese, 2007).

At global level, specific statutory regulation of chiropractic did not exist in most countries. In spite of this chiropractic's presence within healthcare systems, most visibly in the United States, was such that in 1997 the World Health Organisation officially recognised the World Federation of Chiropractic (Dynamic Chiropractic, 1997). In supporting its recognition, the President of the World Federation of Neurologists, who happened to be Lord Walton of

Detchant, described the relationship between the medical profession and chiropractic as “increasingly one of mutual respect and collaboration” (Chiropractic Report, 2001, p. 2). Thus, as in Britain, on the world stage, growing socio-political acceptance of chiropractic was coupled with the idea of its compatibility with medicine.

CHAPTER 10

Conclusion

This, the final chapter of the thesis, affords the opportunity to reflect upon the work as a whole, and to draw together the discussions and arguments of preceding chapters. It begins with an appraisal of the attainments of chiropractic in Britain with respect to professionalisation in the years up to and including 2001. This is followed by an assessment of the legacy that this period of history has bequeathed to the present and a discussion of relevant developments since 2001. The concluding section provides a précis of key arguments developed within the thesis and offers suggestions for further research.

10.1 An appraisal of chiropractic's professionalisation in Britain

In 2001 the title chiropractor came to be protected under British law, but beyond this what was achieved by chiropractic, what was not achieved, and why? Macdonald (1995, p. 188) summarised the practical concerns of professionalisation as: (1) the pursuit of monopoly in the market for services based on specific expertise; and (2) the pursuit of status in the social order. Whereas the professionalisation of chiropractic in Britain in the years leading up to 2001 resulted in increased social status for chiropractors, illustrated by the passing of the *Chiropractors Act* in 1994, it did not result in a monopoly for their services. The Act described chiropractic as a profession, and granted legal protection of title, but no function or activity of chiropractors came to be protected under law.

The Act provided instruction for the setting up of the General Chiropractic Council to govern chiropractic in Britain. In accordance with its remit, in 2000 the GCC accredited courses offered by four British schools for the training of chiropractors, but the *Chiropractors Act* did not prohibit individuals not enrolled on those courses from learning 'chiropractic' techniques. Similarly, although from the 15th June 2001 only those registered with the GCC were legally authorised to describe themselves as chiropractors, there was no requirement for others to refrain from using 'chiropractic' methods, providing that they did not claim to be chiropractors and that they did not claim to be practising chiropractic. The situation was further complicated by overlap in the practices of chiropractors, osteopaths, and physiotherapists, and by diversity of chiropractic opinion in relation to scope of practice (Wilson, 2003a). Of chiropractors, osteopaths and physiotherapists practising in Britain, it

was chiropractors who were the smallest group. By June of 2002 the GCC had registered 1,675 chiropractors (General Chiropractic Council, 2002, p. 15). In the same year the General Osteopathic Council reported that there were 3,215 registered osteopaths in Britain (General Osteopathic Council, 2002), and the Council for Professions Supplementary to Medicine reported that there were 33,835 registered physiotherapists (Council for Professions Supplementary to Medicine, 2002, p. 11). The vast majority of chiropractors worked entirely in the private sector, outside the confines of the NHS. Chiropractors frequently provided for the conservative management of patients with a variety of common neuromusculoskeletal conditions, but were far from dominant in the competitive market for care of such ailments.

Although state licensing provided chiropractors with official acknowledgement of perceived expertise, and implied growing acceptance of chiropractic by the medical lobby, chiropractic continued to be characterised as a form of CAM. Even though chiropractic was described in 2000 in a report of a Select Committee of the House of Lords as one of the “Big 5” of the CAM world (House of Lords Select Committee on Science and Technology, 2000, p. 17), as professionally organised (p. 18), with good evidence of efficacy (p. 31), nevertheless chiropractic’s association with CAM imparted a stigma. It suggested a connection between chiropractic and fringe practices such as crystal therapy and iridology. Furthermore, whilst it was true that many chiropractors had adopted attitudes and values favoured by the medical profession, such as openness to evidence-based practice, non-scientific and quasi-religious ideas continued to exist within chiropractic. Writing in the BCA newsletter *Contact*, Rothman (2004) contended that chiropractic’s rhetoric and dogma had prompted those from medical and scientific communities to think that there was something that ‘smelt funny’ about chiropractic.

Be that as it may, chiropractic had survived in Britain. It had done so because its ideas and practices were sufficiently appealing to society, because its leaders had exhibited strength of will (for example Robert Beech and Donald Bennett in the establishment of the AECC, and Ian Hutchinson and Michael Copland-Griffiths in pursuit of the *Chiropractors Act*), because it had become organised, and because social conditions were favourable. In spite of their differences, chiropractors had established national and international social networks, recognised opponents and would-be allies, exhibited adaptability (for example in their changing relationship with the medical profession and with osteopathy), and come to share a sense of common social purpose (most especially in the lead up to the *Chiropractors Act*). Why then, one might ask, did chiropractic in Britain not achieve more in the years leading up to 2001? Perhaps most importantly, it did not achieve more because it faced competition

from the medical profession, from osteopaths, physiotherapists and others. The medical profession's dominance of the healthcare arena had a restraining effect upon chiropractic. The professionalisation of medicine helped to shape both the nature of the healthcare market and the legislative environment in which chiropractors found themselves. The substance of the *Osteopaths Act* in particular, to a large extent determined the substance of the *Chiropractors Act*.

With respect to chiropractic itself, there can be little doubt that at times limited practitioner numbers adversely affected organised chiropractic's ability to achieve its objectives. If, for example, instead of there being fewer than one hundred chiropractors registered with the British Chiropractors' Association in the 1940s, there had been nearer to a thousand, it is probably reasonable to assume that the demands of chiropractors in relation to the formation of the National Health Service might have been given more attention by government. For many years organised chiropractic in Britain was heavily reliant upon the United States for the training of chiropractors, and it was not until the 1960s, when the Anglo-European College of Chiropractic was founded, that this situation began to change. From the 1970s onwards, as chiropractic numbers increased, the force of the chiropractic lobby grew, and with it the ability of chiropractic organisations to achieve their goals.

Even so, in the period leading up to 2001 chiropractors in Britain failed to achieve a collective consensus on identity. Whereas in the build up to the *Chiropractors Act* a sense of common purpose came to exist amongst those who called themselves chiropractors in Britain, the question 'what is a chiropractor?' remained difficult to answer. In his examination of chiropractic in North America, Wardwell (1992, p. 257) highlighted the issue of identity as one that had "plagued" chiropractic since its earliest days. In Britain, as in America, diversity of beliefs and practices added complexity to chiropractic, and intra-occupational divisions influenced the course of chiropractic's evolution. The 'straight-mixer' debate was central to the dynamics of chiropractic in Britain in the years before the Second World War. In the second half of the twentieth century McTimoney 'chiropractors' became a focus for discussion about legitimacy and the boundaries of chiropractic. Whilst it is true that boundary disputes are ordinarily a part of professionalisation, longstanding or unresolved disputes over occupational boundaries may endanger development. If the BCA had not changed its stance towards McTimoney chiropractors and worked with them in the cause of statutory recognition, the *Chiropractors Act* would probably not have been passed. Conceivably, if chiropractors and osteopaths in Britain (two groups who shared much in common) had joined forces early in their history, rather than becoming professional rivals, more might have been achieved sooner.

10.2 The continuing development of chiropractic in Britain

Viewed from the perspective of professionalisation, the history of chiropractic in Britain from its origins to 2001 confers a multifaceted legacy to the present. On the one hand, there is the inheritance of official recognition and regulation, of legal protection of title, and of improved social position for chiropractors in comparison with previous times. This is an inheritance that requires those wishing to become chiropractors to undergo formal training (which in Britain is now invariably linked to the University system), and that requires those practising chiropractic to abide by defined ethical standards. In these respects chiropractic exhibits features that sociologists would normally associate with 'professional' standing.

On the other hand, the legacy imparted by the history of chiropractic in this country is not of dominance over any particular field of work, and is not of uniform chiropractic opinion on identity. Lines of fracture have existed within chiropractic, and they continue to exist. Tensions remain over credentials (how and where chiropractic qualifications are obtained), over the principles of chiropractic, and over the methods and scope of chiropractic practice. Such issues are not confined to Britain. In the United States, Phillips (2004) has described chiropractic as a "construct of confusion". In Australia, Reggars (2011) has voiced concern over the longstanding impasse between 'evidence-based' approaches to chiropractic and the tradition of 'subluxation-based' care. That is not to say that chiropractors from different nations have not expended energy in efforts to try to find unity in diversity. In point of fact, North American chiropractic schools reached agreement on a "paradigm of chiropractic" in 1996 (Chiropractic Report, 1996). That paradigm was discussed at a meeting of the World Federation of Chiropractic in Paris in 2001, where general agreement was also reached (World Federation of Chiropractic, 2001). The paradigm described chiropractic as a healthcare discipline which emphasized "the inherent recuperative power of the body to heal itself without the use of drugs or surgery". Chiropractic was said to focus "particular attention on the subluxation".

With respect to this thesis a number of things are notable. The first is that not all chiropractic groups were represented in the discussions which took place in Paris in 2001. Although the BCA was represented, there was no official representation from the MCA, the SCA, or the UCA. The BCA was the only British organisation with WFC voting rights. The second is that members of the BCA themselves chose to reject adoption of the paradigm at a special general meeting of the Association held in the spring of 2002 (Contact, 2002). Within the BCA there were those who believed that the word 'subluxation' had had its day; that it was a word that had become burdened by too many different meanings, a word that acted as a

barrier to the integration of chiropractic into modern healthcare systems. Likewise, there were those within the BCA who were concerned about chiropractic opposition to use of medications, and who saw the possibility of a future in which chiropractors practising in Britain might themselves have limited prescribing rights.

Yet the BCA did not represent the opinions of all chiropractors in Britain. Within British chiropractic there were also those who sought to reaffirm traditional Palmerian principles, and who reacted against chiropractic's medicalisation. In this regard the formation of the United Chiropractic Association in 2000 is noteworthy (see pp. 174-175). From its inception the UCA promoted 'subluxation-based' chiropractic, and encouraged chiropractors who shared its philosophy to join its ranks. In the first decade of the twenty-first century the number of chiropractors in Britain grew. By the summer of 2011 there were 2,743 chiropractors registered with the GCC (General Chiropractic Council, 2011). Of these 380 were members of the UCA (United Chiropractic Association, 2011). There were 1,355 members of the BCA (British Chiropractic Association, 2011), 529 members of the MCA (McTimoney Chiropractic Association, 2011), and 142 members of the SCA (Scottish Chiropractic Association, 2011). The UCA had become the third largest voluntary association of chiropractors in Britain (excluding the College of Chiropractors).

Thus old tensions remained within British chiropractic, tensions that were not resolved by the passing of the *Chiropractors Act*. Although it is true that in the lead up to the Act chiropractors united in pursuit of statutory recognition, the *Chiropractors Act* did not resolve deep-rooted disagreements over chiropractic identity. This thesis supports Cant and Sharma's contention (1999, pp. 144-147; see pp. 5-6) that chiropractors de-emphasised controversial elements of their treatment and linked themselves to the established medical paradigm in the years preceding the *Chiropractors Act*, but it is also important to recognise that undercurrents of traditionalism continued to exist within chiropractic, undercurrents that have since resurfaced.

The comments of Simon Singh published by *The Guardian* newspaper in 2008 (see p. 14), and the subsequent lawsuit initiated by the BCA, drew attention to the tensions within chiropractic. Singh wrote (Singh, 2008):

The British Chiropractic Association claims that their members can help treat children with colic, sleeping and feeding problems, frequent ear infections, asthma and prolonged crying, even though there is not a jot of evidence. This organisation is the respectable face of the chiropractic profession and yet it happily promotes bogus treatments.

The BCA found itself having to defend its claims in respect to the chiropractic treatment of paediatric conditions. Singh's article and the legal case that followed it, a legal case which the BCA discontinued in 2010 without a final judgement in its favour (British Chiropractic Association, 2010), highlighted the challenges of defining chiropractic scope of practice in an age of evidence-based medicine. The validity of chiropractic claims, specifically those of the BCA, were called into question.

The first decade of the twenty-first century has been a difficult one for chiropractic in Britain. If truth be told, the chiropractic experience of statutory regulation has not been wholly positive. One effect of the *Chiropractors Act* was to establish a legacy of state-sanctioned bureaucracy. The Act tied chiropractors into a legal arrangement over which the British government would have ultimate control. In this regard changing relationships between professions and successive British governments are relevant. For much of the twentieth century British governments had tended to take a fairly non-interventionist approach to the regulation of the professions, allowing professionals in general, and medical doctors in particular, scope to manage their own affairs. As the century drew towards its close however, this situation altered. In the aftermath of Harold Shipman's killings and of failings of paediatric cardiac surgery at the Bristol Royal Infirmary, the Labour government of the day sought to place new controls on the work of healthcare professionals (Allsop & Saks, 2002, pp. 1-3). This led to a fundamental re-appraisal of the statutory regulation of healthcare professions in Britain, including chiropractic. Chiropractors who in the early 1990s had supported the vision of a General Chiropractic Council over which they would have some say, and which would function to promote chiropractic, found themselves by the end of the first decade of the twenty-first century subject to a General Chiropractic Council whose members were selected by the Appointments Commission (General Chiropractic Council, 2009), and which no longer functioned to promote chiropractic (Dixon, 2008). In addition, the workings of the GCC, along with those of other healthcare regulators, came to be overseen by a new organisation, at first called the Council for the Regulation of Health Care Professionals (Act of Parliament, 2002, sect. 25), but which became the Council for Healthcare Regulatory Excellence (Council for Healthcare Regulatory Excellence, 2010a, p. 3). Where chiropractors had enjoyed a measure of influence over the legal governance of their work subsequent to the *Chiropractors Act*, that authority was taken away from them, an action not in accordance with professionalisation, but with its opposite.

These changes in healthcare regulation call into question the status of all healthcare professionals in the twenty-first century, and even the durability of the concepts of 'profession' and 'professionalisation'. That which we call a 'profession' is in reality the

product of a special equilibrium in dynamic social forces (see Wrightson, 1993, p. 12 for his observations on society as a ‘process’). Although the concepts of ‘profession’ and ‘professionalisation’ have been usefully applied to the study of health occupations in the twentieth century, it remains to be seen how valuable these constructs will be in the future. In Britain today transparency and public accountability are expected of all legally sanctioned professions. Government scrutiny of professions has increased, and professional self-regulation has been challenged.

In the twenty-first century there has been specific criticism from chiropractors of the manner in which statutory regulation has been handled by the General Chiropractic Council.

Although the GCC might be seen to have acted appropriately in protecting the title ‘chiropractor’ from unauthorised use, reporting 55 cases of potential title misuse to the police between 2002 and 2010 (Council for Healthcare Regulatory Excellence, 2010b, p. 5), other actions that it has taken have been more controversial. Following commencement of the BCA’s lawsuit against Simon Singh, the GCC received more than 600 complaints about BCA members (General Chiropractic Council, 2010a, p. 20). They came from a small number of individuals who raised concerns about the therapeutic claims made on chiropractic websites, especially in relation to the treatment of non-musculoskeletal conditions. The manner in which the complaints were dealt with by the GCC, and the fairness (or otherwise) of the proceedings that followed, resulted in dissatisfaction amongst chiropractors. Richard Brown (2010), the President of the BCA, described a “sense of frustration, anger, injustice and resignation”.

In a context of media attention surrounding the Singh case, in order to guide chiropractors in their advertising, the GCC commissioned Gert Bronfort (a chiropractor and researcher from Northwestern Health Sciences University in the United States) and four other chiropractic academics working in North America to produce a report into the effectiveness of chiropractic care for a variety of specified conditions. Upon its publication (Bronfort *et al.*, 2010) the report attracted criticism from chiropractors. The Scottish chiropractor Graeme Wight (2010) wrote:

Can someone enlighten me (and I suspect most others in the UK profession) who this gentleman [Bronfort] is and what are his credentials to be dictating what we in chiropractic can/cannot claim to treat?

Likewise, when the GCC produced guidance on the ‘vertebral subluxation complex’ that suggested it should be considered an historical concept, a theoretical model whose

application to the cause of disease was not supported by clinical research evidence (General Chiropractic Council, 2010b), the UCA responded in defence of the subluxation. The Association published a statement that included the following extract (United Chiropractic Association, 2010):

The UCA is deeply disappointed that our regulator has released this guidance. Segments of the Chiropractic profession would like to promote Chiropractic as a limited scope mechanistic profession and in relation to promotion and advertising this guidance adds credence to this. This is not the view of the UCA. We realize that many of our members and Chiropractors internationally chose their career paths as Chiropractors because there is more to what we offer than just the relief of mechanical pain syndromes. Chiropractors have long made empirical observations in their practices as to the various outcomes related to their care and the adjustment however; we have not been as good in researching such outcomes beyond the purely mechanical, such as chronic low back pain. Nevertheless this does not discount the principles by which a Chiropractor may practise.

In October of 2010 the Presidents of the BCA, the MCA, the SCA and the UCA wrote as one to the GCC expressing a lack of confidence in the GCC's process, interpretation and proportionality in its regulation of chiropractic (Brown *et al.*, 2010). Although they stated that they were supportive of chiropractic regulation, they maintained that they were "deeply unhappy" with the manner in which regulatory functions had been managed.

With respect to the foregoing discussion, it is appropriate to view the GCC's actions in the context of its primary duty, which has always been to protect the public. In addition, it is fitting to recognise that from the perspective of the scientist who is sceptical of chiropractors' claims, the GCC's approach may seem to have been entirely justified. It is not the function of this thesis to pass judgement on the GCC's actions, nor to judge the validity or otherwise of chiropractic objections. What is important to highlight here is that the realities of chiropractic statutory regulation proved more challenging than some within chiropractic might have predicted or wished for.

10.3 Final summation

As described in the Introduction, the aim of this thesis was to explore and critically evaluate the history of chiropractic in Britain from its origins to the point of protection of title in 2001. The lens of 'professionalisation' has been used to assist in this.

As we have seen, chiropractic had complex origins. It is misleading to claim that chiropractic was ‘discovered’ by Daniel David Palmer, or that chiropractic in Britain was entirely an ‘import’ from the United States. On both sides of the Atlantic there were systems and ideas similar to Palmer’s chiropractic that preceded it. Even so, the name ‘chiropractic’ was chosen by Daniel Palmer and first applied to his practice. He and his son, Bartlett Palmer, packaged and marketed chiropractic. Their followers were influential in shaping the subsequent dynamics of chiropractic in Britain.

In defining the principles of his chiropractic, Daniel Palmer combined empiricism with metaphysical notions, producing a system of beliefs that stood in opposition to the medical orthodoxy of its day. Daniel Palmer’s chiropractic was not intended to be an adjunct to medical orthodoxy, but instead an alternative and exclusive system of healthcare. During chiropractic’s early development in the United States, when chiropractors were frequently accused of practising medicine illegally, it was in the interest of chiropractors to emphasise their differences from medical doctors in order to defend themselves in the courts. In Britain, legal conditions were not the same. Because chiropractic was tolerated under common law, chiropractors were not subject to the same legal challenges as in the United States. Consequently, there was not the same legal incentive for chiropractors to emphasise their differences from medical doctors.

The professional evolution of chiropractic in Britain was intertwined with that of osteopathy. In the early part of the twentieth century both groups assumed marginal and heterodox positions within British healthcare. The distinction between them was not clear-cut, and there existed a middle ground where they blended in an atmosphere of therapeutic ‘mixing’. It was osteopaths, rather than chiropractors, who first attempted to differentiate themselves from other practitioners of manipulation by forming associations and by initiating processes of political agitation. To a large extent the early development of osteopathy in Britain forced the pace of chiropractic’s development.

As previously illustrated, the formal organisation of chiropractic in Britain began in the 1920s. From 1925 onwards membership of the BCA provided chiropractic ‘purists’ (those with the strongest communal and ideological ties to the Palmers) with a means of separation from osteopaths and from persons who ‘mixed’ chiropractic manual techniques with other remedial methods. The BCA acted as a trade union for chiropractors who had trained in the United States, and it refused to recognise short-lived schools which came into existence in Britain between the World Wars, schools that purported to teach chiropractic alongside other forms of natural healing. During the 1930s and 1940s many of those who inhabited the

middle ground between chiropractic and osteopathy came to describe themselves as osteopaths.

The Second World War marked a turning point in the development of chiropractic in Britain. The BCA was adversely affected by the War, and afterwards by the exclusion of chiropractors from the National Health Service. Of fundamental importance to the subsequent history of chiropractic in Britain is the fact that the BCA successfully adapted to the challenges that it faced at this time. In a spirit of ‘aggiornamento’ the Association’s advocacy of traditional Palmerian principles was called into question and its stance towards ‘mixing’ relaxed. In the absence of appreciable competition, the BCA became the only major representative body for chiropractors practising in Britain.

Members of the BCA had played a pivotal role in the formation of the European Chiropractic Union in the 1930s, and in the post-World War II period it was BCA members who rose most successfully to the challenge of establishing a pan-European chiropractic school. For several years the Anglo-European College of Chiropractic, which opened its doors to students in 1965, held the monopoly in provision of formal chiropractic education in Europe, but in 1972 this state of affairs was challenged when John McTimoney’s Oxfordshire School of Chiropractic came into being. The emergence of McTimoney chiropractic muddied occupational waters, and once again brought to the fore issues of identity and legitimacy in respect to use of the title ‘chiropractor’. During the 1970s and 1980s the BCA did not recognise graduates of the McTimoney School as *bona fide* chiropractors. The geography of chiropractic in Britain was further complicated when one of John McTimoney’s students, Hugh Corley, set up another competing school in 1984. In spite of their differences, it is important to recognise that these schools furthered the formalisation of chiropractic education in Britain.

In this thesis it was argued that professions are by nature orthodox occupations, and contended that a non-orthodox occupation might become orthodox either by: (1) supplanting a prevailing orthodoxy; (2) becoming a concurrent orthodoxy; or (3) becoming part of an established orthodoxy. In Britain, in the second half of the twentieth century, chiropractic moved towards orthodoxy primarily along the third of these paths. Chiropractic medicalised. It did so in the presence of diversity in chiropractic opinion and practices, for there were chiropractors who resisted change and those who held fast to traditional Palmerian principles. Even so, the prevailing movement, the direction pursued by chiropractic’s most influential elites, was as described. Medicalisation of chiropractic, and more importantly the

perception of its medicalisation, helped to appease the medical lobby and aided chiropractors in their pursuit of statutory recognition.

By the early 1990s it became apparent that a precondition of chiropractic's statutory recognition would be broad-based intra-occupational unity. The BCA had to recognise McTimoney and McTimoney-Corley chiropractors as legitimate colleagues and be prepared to work with them, which it did. In the cause of legal sanction chiropractic associations de-emphasised their differences and presented a unified front. They worked together and collaborated with osteopathic groups for mutual benefit. These actions paved the way for the passing of the *Chiropractors Act* and for protection of title.

Chiropractors in Britain smoothed over their differences in order to achieve a common strategic aim, that of statutory recognition, but tensions remained within chiropractic. In the twenty-first century those tensions resurfaced, and in Britain today chiropractic stands at a juncture where groups adhering to different ideologies grapple to determine its future. From the discussions in foregoing chapters it can be deduced that in Britain chiropractic was subject to processes that can be described in terms of professionalisation, sharing features in common with the professionalisation of other occupations described in historical and sociological literature. During the early part of their history chiropractors professed theories that helped to define an area of work. They made a commitment to that area of work, and established sapiential authority over patients. Chiropractors working in Britain formed associations, developed formal codes of ethics, and set up training facilities which in the fullness of time became linked to the university sector. These things were instrumental in establishing a 'professional culture'. Ultimately, political campaigning by chiropractors and by their supporters led to statutory regulation of chiropractic in Britain and to legal protection of title. Chiropractors attained a position of increased legitimacy within British society.

This thesis highlights the complex nature of chiropractic's development in Britain. Through the course of their history chiropractors were frequently divided in beliefs and behaviours, and it would be erroneous to view the evolution of chiropractic in Britain in terms of a wholly unified and conscious attempt by chiropractors to professionalise. Furthermore, chiropractic's professional development was dependent not only upon the actions of chiropractors themselves, but also upon a wide variety of external factors. The professionalisation of osteopathy, the rise of CAM, developments within orthodox medicine, the actions of political elites, and changing social attitudes towards healthcare – these and other factors played a part in chiropractic's professionalisation.

Chiropractic's professionalisation did not follow a linear path, and it did not result in chiropractors attaining an equivalent social standing to medical doctors or lawyers. Even though chiropractic was described as a 'profession' by the *Chiropractors Act*, chiropractors did not attain monopoly of function in the marketplace for the services that they provided. Even for patients with back pain, chiropractors were not the first port of call, and most continued to work exclusively in the private sector, outside the confines of the NHS. In addition, although the *Chiropractors Act* provided benefits for chiropractors, and led to protection of title, the Act represented a regulative bargain through which chiropractic practitioners lost a degree of control over their sphere of work, becoming more directly accountable to government than before.

The chapters of this thesis draw attention to source materials that have not been considered by other contemporary authors, and shed new light on the history of chiropractic, but they also offer scope for further detailed research. This study has focused primarily on the years up to and including 2001. The development of chiropractic in Britain since 2001 has been given some focused attention in this chapter, but warrants further analysis. Similarly, the focus on chiropractic's professional development has necessarily acted as a constraining factor and aspects of chiropractic's history have been excluded from the thesis because of it. Additional details of the 'pioneers' of chiropractic in Britain (including biographical information and particulars of practice) were uncovered during fieldwork that were not considered sufficiently relevant for inclusion in the thesis. Some of those details have been presented elsewhere (See: Wilson & Wilson, 2007; Wilson, 2008). Others might be appropriate for inclusion in life histories of those individuals, should they come to be written. Likewise, further details of the history of the AECC came to light that have not been included in the thesis, but which would probably be of interest to a researcher undertaking a detailed study of that institution. Further research might also usefully be applied to the evolution of other chiropractic schools or groups, or to the development of chiropractic in Britain from the perspective of economics, advertising, or geography.

In Britain chiropractors have become recognised by law as legitimate providers of healthcare. They have achieved this in significant part through medicalisation of their field of work. Today's paradigm of evidence-based medicine encourages practitioners to view clinical practice within a scientific framework, as an applied science. It discourages the use of tradition as a primary justification for practice methods. That being the case, it is necessary to recognise that unquestioning adherence to traditional beliefs within chiropractic risks its future integration into mainstream healthcare.

APPENDIX 1

List of libraries and archives at which research was undertaken

The Origins and Professional Development of Chiropractic in Britain

Libraries and archives in the United Kingdom:

Archives and Special Collections of King's College, London
British Library, London
Donald and Elizabeth Bennett History Library, Anglo-European College of Chiropractic, Bournemouth
Edinburgh Central Library
John Rylands University Library, Manchester
Library of the British College of Osteopathic Medicine, London
Library of the British Medical Association, London
Library of the British School of Osteopathy, London
Library of the McTimoney College of Chiropractic, Oxford
Manchester Central Library
National Archives at Kew, London
National Osteopathic Archive, Oxford storage
Plymouth and West Devon Record Office, Plymouth
Plymouth Central Library
University of Southampton Libraries
University of Surrey Library, Guildford
Vilhelm Krause Library, Anglo-European College of Chiropractic, Bournemouth
Wellcome Library for the History and Understanding of Medicine, London

Libraries and archives in the United States:

A.T. Still Memorial Library, Kirksville College of Osteopathic Medicine, Missouri
Burlington Public Library, Iowa
David D. Palmer Health Sciences Library, Palmer College of Chiropractic, Davenport, Iowa
Library and Archives of the National University of Health Sciences, Lombard, Illinois
Special Collections and Archives of Palmer College of Chiropractic, Davenport, Iowa
Still National Osteopathic Museum, Kirksville, Missouri

APPENDIX 2

Subjects who provided oral testimonies for the study

The Origins and Professional Development of Chiropractic in Britain

Interviewee	Date of interview	Reasons for interview
Donald Bennett (Retired chiropractor)	14.08.03	Donald Bennett was chosen because as a founder of the Anglo-European College of Chiropractic it was thought that he would be able to provide insight into the beginnings of the School. It was also recognised that as an ex-President of the British Chiropractors' Association he would have first-hand knowledge of that Association's history.
Stuart Wight (Retired chiropractor)	30.05.05	Stuart Wight was chosen because as a son of Leslie Wight (who had set up a chiropractic practice in Edinburgh in 1924), and as a founding member of the Scottish Chiropractic Association, it was thought that he would be able to provide a well-informed Scottish perspective on the professional development of chiropractic in Britain.
Gerhild Melvill	01.12.05	Gerhild Melvill was chosen because as the wife of the late Robert Melvill (the only student from the first group to study at the Anglo-European College of Chiropractic to qualify from the School) it was thought that she would be able to offer a valuable view of the beginnings of the School. It was recognised that her perspective would probably be different from that of Donald Bennett.
Michael Howitt Wilson (Retired general practitioner and chiropractor)	20.05.08	Michael Howitt Wilson was chosen because as one of only a very few medical doctors to have studied chiropractic in Britain it was thought that his view of chiropractic's professional development might be different from the other chiropractors interviewed. He was a member of the British Institute of Musculoskeletal Medicine, and had previously been a member of the British Association of Manipulative Medicine.

Interviewee	Date of interview	Reasons for interview
Michael Copland-Griffiths (Chiropractor)	23.05.08	Michael Copland-Griffiths was chosen because as an ex-President of the British Chiropractic Association, as a key mover in efforts towards the statutory regulation of chiropractic in Britain, and as the first President of the General Chiropractic Council, it was thought that he would be able to offer valuable insight into the history of chiropractic regulation in this country.
Malcolm Morrison (Retired consultant orthopaedic surgeon)	05.06.08	Malcolm Morrison was chosen because as a medical manipulator and member of the British Institute of Musculoskeletal Medicine, and as a former member of the British Association of Manipulative Medicine, it was thought that he would be able to offer an erudite 'medical' perspective on the professional development of chiropractic in Britain.
Alan Breen (Chiropractor)	07.06.08	Alan Breen was chosen because of his personal involvement in, and knowledge of, the development of chiropractic research in Britain. He was also chosen because of his experience as a chiropractic educator, and because he had previously described himself both as a chiropractor and as an osteopath.
Lord Walton of Detchant (Retired consultant neurologist)	18.06.08	Lord Walton was chosen because of his first-hand experience and knowledge of chiropractic at Parliamentary level. It was thought that he would be able to provide special insight into the developments that led to the statutory regulation of chiropractic in Britain. Lord Walton was a Past-President of the British Medical Association. He was a member of the King's Fund Working Party on chiropractic that reported in 1993, and was Chair of the Select Committee on Science and Technology that reported on complementary and alternative medicine in 2000.
Sidney Hudson-Cook (Retired chiropractor)	20.06.08	Sidney Hudson-Cook was chosen because it was thought that he would be able to provide unique insight into the beginnings of the Anglo-European College of Chiropractic. His dismissal as a lecturer at the School was instrumental in bringing about the student revolt of 1967. As well as practising as a chiropractor he described himself as an osteopath.

Interviewee	Date of interview	Reasons for interview
Stan Harding (Retired chiropractor)	Written testimony dated 05.07.08	Stan Harding was contacted because of his knowledge and experience of McTimoney Chiropractic, having been trained by John McTimoney. It was thought that he would be able to provide particular insight into the history of the McTimoney Chiropractic School of which he had been Principal. He chose to provide a written testimony.
David Lidington MP	08.07.08	David Lidington was chosen because he introduced the Private Member's Bill that became the <i>Chiropractors Act</i> in 1994. It was thought that he would be able to provide a pertinent perspective on the history of chiropractic statutory regulation.
Ian Hutchinson (Chiropractor)	18.07.08	Ian Hutchinson was chosen because he was a key mover in the actions that led to the Chiropractors Act. It was thought that he would be able to offer valuable insight into those actions. He had been President of the British Chiropractic Association on two occasions.
Colin Dove (Retired osteopath)	04.08.08	Colin Dove was chosen because of his knowledge and understanding of osteopathy in Britain and its relations with chiropractic, having been Principal of the British School of Osteopathy. It was thought that he would be able to offer a meaningful 'osteopathic' perspective on the professional development of chiropractic in Britain.
John Matthews (Physiotherapist)	19.08.08	John Matthews was chosen because as a physiotherapist working in the private sector his practice had for many years been in competition with local chiropractic clinics. It was known that his views on chiropractic were not entirely positive, and it was thought his opinions on the professional development of chiropractic might usefully challenge those of the researcher.
Joan Nind (Retired chiropractor)	20.08.08	Joan Nind was chosen because as a chiropractor who had trained through an apprenticeship with Mary Walker it was thought that she would be able to offer a unique perspective on the professional development of chiropractic in Britain and on the development of McTimoney Chiropractic in particular.

Interviewee	Date of interview	Reasons for interview
Ann Moore (Physiotherapist)	28.08.08	<p>Ann Moore was chosen because of her personal involvement in, and extensive knowledge of, manual therapies. It was thought that she would be able to offer a scholarly 'physiotherapist' perspective on the professional development of chiropractic in Britain. At the time of interview she was Head of the Clinical Research Centre for Health Professions at the University of Brighton, a Fellow of the Manipulation Association of the Chartered Society of Physiotherapy, Executive Editor of <i>Manual Therapy</i>, and Chair of the National Council for Osteopathic Research.</p>

APPENDIX 3

Participant information sheet for the main series of interviews

The Origins and Professional Development of Chiropractic in Britain

PARTICIPANT INFORMATION SHEET

Title of Study: The Origins and Professional Development of Chiropractic in Britain

Background to the study

The proposed interview will form part of a PhD project intended to go some way towards answering the question: 'How did chiropractic in the United Kingdom get to where it is today?' The PhD is in itself part of a wider project aimed at developing a better understanding of the history of chiropractic within Europe.

The work is being financially supported by the European Chiropractors' Union. The researcher, Francis Wilson, is a member of faculty at the Anglo-European College of Chiropractic and is registered with the University of Southampton for the project.

What will be involved?

As part of this study I am interviewing a number of individuals who it is felt can shed light on the development of chiropractic in Britain. With your agreement, you will be interviewed in order to provide an oral testimony relating to the history of chiropractic in Britain. The interview will be recorded onto minidisc and will later be transcribed in order to facilitate data analysis. Interview questions will focus on areas of your experience, and events and issues in the history of chiropractic with which you are likely to be familiar. Interviews are expected to take between one to two hours.

Why have I been chosen?

You have been chosen because it is thought that you will be able to give valuable insight into the development of chiropractic in Britain that will usefully add to the information that can be gathered from written documents at the present time.

Your involvement is voluntary and you may withdraw from the study at any stage. No reason for withdrawal is required.

PLEASE TURN OVER

How will data obtained from interviews be used?

A. Use of data in relation to the PhD study

During the course of the PhD study, interview data (minidisc recordings / transcribed material) will be stored in a secure environment for use in relation to the study. In other studies that you may be familiar with, or have taken part in, confidentiality is assured. For the purposes of this study however, it is who you are, and your specific experience of chiropractic in Britain, that makes your input of particular value in historical terms. Information obtained from your interview will be attributed to you by name, unless you make it clear that you wish otherwise. This information will appear in the final version of the PhD thesis, and may also be drawn upon for publications arising from the research. Where data from your interview are to be used in the thesis or for a publication, I will make every reasonable effort to contact you in order to check the accuracy of the statements you have made before submission.

B. Use of data thereafter

As well as being of value to this project, your named testimony may also give insight to future researchers examining chiropractic history. It is my intention that, with your agreement, your interview data should be lodged as part of an oral collection at the Anglo-European College of Chiropractic History Library, and that the College should be able to provide access to the data for future research. As interviewees own the copyright to their own words, you are asked to transfer copyright to the Anglo-European College of Chiropractic, so that, for example, data can be transferred from one medium to another without needing to contact you. Again, there is no requirement for you to agree to this. The decision is yours. Please let me know if you do NOT want interview material to be made available in this way, in which case recordings and interview transcripts will be destroyed at the end of the current research study.

If at some time in the future a request is made by an external body for copies of interviews stored in the oral collection of the Anglo-European College of Chiropractic History Library, every reasonable effort will be made to ensure that you are consulted and approve of transfer before it is undertaken.

For further information...

If you have any further questions, or require any more information, please do not hesitate to contact me:

Francis J H Wilson, DC, MSc, FCC, FHEA, FEAC (Research), Anglo-European College of Chiropractic, Parkwood Road, Bournemouth, Dorset BH5 2DF.
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APPENDIX 4

Interview consent form and deposit agreement for the main series of interviews

The Origins and Professional Development of Chiropractic in Britain

INTERVIEW CONSENT FORM AND DEPOSIT AGREEMENT

Title of Study: The Origins and Professional Development of Chiropractic in Britain

Instructions: Please read the following statements and mark with your initials those statements with which you agree. Please do not initial statements with which you do not agree. One copy of this consent form should be kept for your records and one copy should be given to the researcher before you are interviewed.

Name and contact address:

Initials

1. I have read and understood the participant information sheet about this study.

2. I have had the opportunity to discuss any issues with the researcher.

A. Use of data in relation to the PhD study

3. I agree to take part in the research on the basis set out in the participant information sheet.

B. Use of data thereafter

4. I give permission for my interview data to be lodged as part of an oral collection at the Anglo-European College of Chiropractic History Library on the basis set out in the participant information sheet.

5. I hereby assign the copyright of my contribution to the Anglo-European College of Chiropractic.

Participant's signature..... Date.....

APPENDIX 5

An example of an interview guide used during the study

The Origins and Professional Development of Chiropractic in Britain

Interview with Lord Walton of Detchant on 18th June 2008

Interview format: Semi-structured oral history.

Background: Lord Walton qualified in medicine at the Newcastle Medical School of Durham University in 1945 and obtained his MD in 1952. He became a Consultant Neurologist to the Newcastle upon Tyne group of hospitals in 1958. In 1968 he became a Professor of Neurology and from 1971-81 he was Dean of Medicine at Newcastle. He was awarded a Life Peerage in 1989. He was President of the British Medical Association from 1980-82. He was a member of the King's Fund Working Parties on Chiropractic and on Osteopathy in the early part of the 1990s. He Chaired the Sub-Committee of the Select Committee on Science and Technology which produced a report on CAM in November 2000 (Science and Technology, Sixth Report).

Initial contact with chiropractic and osteopathy

- When did you first hear of chiropractic? Do you remember what your attitude was towards chiropractic in the years after you first heard of it? Why was that?
- When did you first hear of osteopathy? Was your attitude towards osteopathy the same or different from your attitude towards chiropractic?
- As a Consultant Neurologist for the Newcastle upon Tyne group of hospitals did you have any clinical interactions with either osteopaths or chiropractors? [If so] can you tell me about your clinical relationship with these practitioners?
- What was the attitude of medical doctors in general towards chiropractors and osteopaths in the 1950s and 60s?

British Medical Association / Prince of Wales

- I understand that you became a Professor of Neurology in 1968 and that from 1971-81 you were Dean of Medicine at Newcastle Medical School. You went on to become President of the BMA in 1980.
- In 1982 His Royal Highness the Prince of Wales took over from you as President of the BMA and at the 150th Anniversary Council Dinner he gave a speech entitled 'Complementary Medicine'. What do you remember of that speech? What were your feelings at the time? In retrospect, what are your views on that speech?

- How influential do you think the Prince of Wales has been in changing attitudes within British society towards CAM?

[Aide mémoire. Extract from the Prince's speech: "I would suggest that the whole imposing edifice of modern medicine, for all its breathtaking successes is, like the celebrated Tower of Pisa, slightly off balance."]

King's Fund Working Parties on Osteopathy and Chiropractic / Chiropractors Act

- You were a member of both the King's Fund Working Party on Osteopathy and the King's Fund Working Party on Chiropractic in the early 1990s.
- How did these Working Parties come to be set up? Please tell me how and why you became involved in these Working Parties and your recollections of them.
- When did you develop a favourable attitude towards statutory regulation for chiropractic? Why was that?
- Did your attitude towards chiropractic change in any way as a result of your involvement in the Working Party on Chiropractic? [If so] why?
- Were you aware of internal disagreements between those who called themselves chiropractors at the time? What can you tell me about them?
- What are your recollections of the events leading up to and surrounding the Chiropractors Act of 1994?
- Was there opposition to the Chiropractors Act? From where? What form did the opposition take?

Lords Select Committee on Science and Technology

- I understand you have been active in Select Committees on Science and Technology and on Medical Ethics. You Chaired a Sub-Committee which produced a report on CAM in November 2000.
- How did the Sub-Committee come to be set up?
- Please tell me how and why you became involved and your recollections of it, particularly in relation to chiropractic.

Professionalisation (general questions)

- Do you think the place of chiropractic within British society has changed in any fundamental way since the end of the Second World War?
- Generally speaking, do you think medical attitudes towards chiropractic have changed? Has chiropractic's relationship with medicine changed?
- What factors do you think have been most important in chiropractic's development in the UK?
- What factors have hampered chiropractic's development in the UK?

- Chiropractic has had some negative press recently. In retrospect, do you think that the Chiropractors Act was a good thing?
- Do you think it would have been better if there had been a single Act to cover both osteopathy and chiropractic?

Miscellaneous

- Is there anything else that you would like to tell me about that might be relevant to my research?

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