

**HEALTH CARE PROFESSIONALISATION
A CASE STUDY OF OSTEOPATHY IN THE
UNITED KINGDOM AND THE
OSTEOPATHS ACT 1993**

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Abstract

This investigation of health care professionalisation uses a case study method to further knowledge on the topic. The subject of the case study is osteopathy in the United Kingdom. Data analysis comprised a qualitative thematic approach, which was interpreted from a sociological perspective, focussing on the developments that were central to a professionalisation process. The primary event in the professionalisation of osteopathy in the United Kingdom was the Osteopaths Act 1993.

The data collected comprised two forms; a) documentary archive relating to the development of osteopathy in the United Kingdom during the Twentieth Century, b) interview data from key players involved in the events preceding the Osteopaths Act 1993.

Data analysis suggests that the osteopathic community continually strived through the Twentieth Century for statutory recognition, to protect a professional title. The first opportunity for legislative change occurred during 1935. This resulted in a House of Lords Select Committee investigation, that concluded; osteopathy was not supported by scientific evidence, and recommended that a voluntary register should be established.

Legislative change was finally achieved with the Osteopaths Act 1993. This appears to have been achieved after intense lobbying by osteopaths in the United Kingdom, and utilising the patron of strategic elites. The legislative change occurred after developments to standardise osteopathic education and maintaining a successful voluntary register. The previously encountered barrier of medical resistance concerning the lack of scientific support, which thwarted the attempt of legislative change in 1935, was finally overcome in response to social and political pressure. Social changes in health care during the decades following World War II; resulting in wider usage of osteopathy across all social groups, combined with a political climate of establishing a 'market' within the National Health Service during the 1980's, created a window of opportunity, which allowed a small number of politically active osteopaths to achieve their ultimate goal, legislative change.

Central to achieving this outcome, was the establishment of highly successful personal networks by this small group of politically active osteopaths, enabling access to strategic

elites (policy makers), in particular HRH the Prince of Wales, and the Kings Fund.

The Osteopaths Act 1993 is seen by the osteopathic community in the United Kingdom as evidence of finally becoming a legitimately recognised health profession. The aim of policy makers though, was to secure benefit and protection to the general public; legislation was not a reward to osteopaths.

What is not clear; is what status others groups in society (professional and lay) regard osteopathy, and whether the Osteopaths Act 1993 has resulted in further recognition and the raising of United Kingdom osteopaths' professional status, or merely been part of the broader development in modern health care regulation?

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Preface

What is osteopathy? A question that returns many varied and contradictory replies. I hope this investigation might inform a little more, and help direct where next to look for an answer?

Acknowledgements

I would like to thank Dr Jan Leach, Dr Phil Mandy and Dr Paddy Maguire for their wise counsel during the process of this investigation.

At times, life became too busy; but the support from my supervisors helped me focus, buckle down and keep going. Thank you.

Declaration

I declare that the research contained in this thesis, unless otherwise formally indicated within the text, is the original work of the author. The thesis has not been previously submitted to this or any other university for a degree, and does not incorporate any material already submitted for a degree.

Signed

A handwritten signature in black ink, appearing to be 'T. McClune', is centered on a light gray rectangular background.

Name Timothy DM McClune

Date 5 April 2011

Chapter 1

1.1 Introduction

The term given to the development of an occupational group towards greater organisation, social status, recognition and legislative protection, is *professionalisation*. A profession has been defined as:

'an occupation which has assumed a dominant position in a division of labour, so that it gains control over the determination of the substance of its own work'
(Freidson, 1970, p.xv)

This study investigated the process of professionalisation within health care, using osteopathy in the United Kingdom (UK) as a case study. The study explored the developments of osteopathy in the UK from a sociological perspective, analysed data and interpreted the results within the context of broader health care professions' development in the UK, particularly medicine.

Medicine has been the dominant health care profession in the UK since the Medical Act of 1858, reinforced by the National Health Service Act 1946 (Freidson, 1970, pp.34-36). Other health care groups have established a professional status of their own, using statutory legislation, but always under the shadow of medicine (Freidson, 1970, pp.48-53). Osteopathy has existed independent of other health care groups in the UK, outside of the National Health Service (NHS), with English Common Law allowing considerable freedom to practice (Baer, 1984, p.718).

Osteopathy developed from the ideas of an American physician, Andrew Taylor Still, in the latter part of the Nineteenth Century. The concept and practice of osteopathy has spread around the world to create a significant group of health care providers. The exact form of clinical practice is dependent on location. In the United States of America (USA), doctors of osteopathy (DO's) have equal practice rights to doctors of medicine (MD's); whereas in Europe, osteopaths' practise in a much more restricted way, occupying a position somewhere between mainstream medicine and complementary and alternative medicine (CAM) (Baer, 1984, pp.717).

There has been limited investigation of developments in osteopathy within the literature, some sociological study of osteopathy in the USA by Baer (1981, 1987, 1989) and Miller (1998), with even less investigation of osteopathy in the UK (Baer, 1984; Lee-Treweek, 2002; Collins, 2005; O'Brien, 2007).

1.2 Background

The workforce, including professions, and the relationship of work to society, have been a subject for scholarly investigation since the late Nineteenth Century, when the sociologists Emile Durkheim, Max Weber and Karl Marx developed a new science for the study of society, *sociology*. They studied social structures and presented their findings and ideas, which included observations on occupational groups and their place in the structure and function of society. Durkheim published the 'Division of labour in society' (1893), Weber published 'The Protestant ethic and the spirit of capitalism' (1904) and Marx published 'Capital, Volume 1' (Das Kapital) (1867). Previous to this, Adam Smith, the social philosopher often hailed as the father of modern economics and capitalism, presented his ideas on economic structures and occupational analysis over a hundred years earlier, with his publication 'The Wealth of Nations' (1776). This early analysis by Smith, of wealth creation and the division of labour, provided a basis for the analysis during the Nineteenth Century, by Durkheim, Weber and Marx.

Since then, sociological study of professions has almost continuously and laboriously focussed on defining a *profession*, and investigating what is and what is not a profession (Evetts, 2003, p.395). Theory on professions have been proposed, critiqued and refined over time, reflecting new knowledge and changing social theories. This has resulted in the rejection of the early model of a profession as an essential ingredient for a civil society – trait approach (Carr-Saunders, 1933; Marshall, 1939; Parsons, 1939) - to an acceptance of the self-interested power of professions that needs careful monitoring and regulation (Freidson, 1970, pp.380-382); in effect a turning on its head, sociological theory on professions (Larson, 1977, pp.237-244). The result of further changes in society, regulation and de-regulation, has resulted in the emergence of the phenomenon of de-professionalisation (Clark, 2005, pp.182-190). This development in understanding

professions more fully, has shifted the focus of sociological study on professionalisation, to the importance of professionalism, particularly professionalism of the individual (Evetts, 2003, pp.395-396; Freidson, 2001, pp.4-7).

This study aimed to investigate the process of professionalisation in health care using osteopathy in the UK as the subject for a case study. Osteopathy has been practised as a form of healing in the UK since the early days of the Twentieth Century. This form of healing was introduced to the UK by a number of North American osteopaths, most notably John Martin Littlejohn (Collins, 2005, p.15; Baer, 1984, p.717). There have been suggestions that bone-setting, a more ancient form of healing that had been practised in the UK for many years previously, had similarities with osteopathy (Gevitz, 1982, pp.17-18). Indeed the founder of osteopathy, Andrew Taylor Still, advertised himself as a 'lightning bone-setter', and Baer (1984, p.717) reinforces the connection between osteopathy and bone-setting, adding that 'in essence what he (Still) may have done was to add a theoretical rationale to a pre-existing empirical practice' (Baer, 1984, p.717).

Since the early pioneering years of development in the USA, osteopathy eventually established itself as a mainstream health profession, although this wasn't widespread in all States until the 1970's. Since then, throughout all States in the USA, osteopathy has developed further and become integrated into mainstream health care to become fully equivalent to a medical training and allowing for full medical practice rights (Baer, 1984, p.717).

Osteopathy has not developed in the UK in the same direction, or to the same extent. Osteopathy in the UK, has always been practised on the margins of health care, never formally integrated into the NHS -except for a few local contracts during General Practice (GP) fund holding in the 1990's - and was not fully integrated into the mainstream universities until very recently. At present a small number of new universities provide a degree course in osteopathy, and the established osteopathic schools now deliver a degree course validated by a UK university (osteopathy.org.uk).

There are also differences between osteopathy practised in the UK compared to that of other European States. There are different regulatory arrangements within European States, with the result that clinical practice differs considerably. For example, in France and

Belgium, osteopaths focus on visceral health problems, and osteopaths in these European States have strict limits on their scope of practice with regard to spinal manipulative therapy (www.efo.eu/portal/index.php). The lack of development of osteopathy in Europe generally may be the result of a limited scientific evidence base (McClune, 2007; Licciardone, 2007, p.1). Medicine has significant scientific evidence to support clinical practice, which has positioned it at the top of the 'status' hierarchy for health care professions. The history of modern Western medicine, clearly shows without exception, all health care groups compete against medicine for a place within a health care system. Health care is a competitive market, but medicine has a monopoly, controlling the market and establishing dominance in contracts with central government - complete domination (Freidson, 1970, pp.48-53). The phenomenon of medical dominance within health care has been studied in depth by sociologists, most notably Eliot Freidson (Freidson, 1970, 1974, 1986, 2001).

Arguably the most significant event in osteopathy's development within the UK during the Twentieth Century, was the passing of the Osteopaths Act 1993. The Act resulted in the creation of a statutory regulatory body, the General Osteopathic Council (GOsC). The Council has a number of statutory roles (www.osteopathy.org.United Kingdom/about/our-work/):

- i) Protection of title 'osteopath'.
- ii) Operating a fitness to practice/complaints scheme.
- iii) Settings Standard of Practice and Code of Practice.
- iv) Monitoring annual continuing professional development (CPD) and registration.
- v) Validating recognised qualifications (RQ) at osteopathic training institutes.

The aim of this study was to add to the sociological literature on health care professionalisation, with a specific aim to investigate what the aspirations were for osteopaths in the UK during the last Century with regard to their legal status of practice, how any changes occurred and whom was responsible for such changes.

This background to the study helps to identify where the gaps in knowledge are, regarding osteopathy in the UK and its status as a health care profession. These gaps in knowledge helped to develop the specific research questions for this investigation.

1.3 Research Questions

Osteopathy's position within health care in the UK is unusual, in that it has existed on the fringe of mainstream health care throughout the Twentieth Century (Baer, 1984, p.717), then suddenly achieved legislative change with The Osteopaths Act 1993 .

The 'Act' did not define osteopathy, and although there is recognition by osteopaths in the UK of a shared heritage, there exists a wide variety of opinion on the scope of clinical practice and the principles that support osteopathic practice:

'At present, there is a considerable lack of clarity around what constitutes osteopathic practice'

(GOsC Osteopathic Practice Framework Consultation, 2009)

Therefore a widely agreed definition of osteopathy is not easily found.

This study aimed to answer specific questions about the professionalisation process of osteopathy in the UK, which focussed on the aspirations and events that preceded the Osteopaths Act 1993.

1. What were the aspirations of UK osteopaths involved in a professionalisation process?
2. How did osteopaths in the UK achieve legislative change in the Osteopaths Act 1993?
3. Does the development of osteopathy in the UK follow a model of professionalisation like any other health care group?
4. Does the data from investigating professionalisation of osteopathy in the UK, help to answer the broader question of, what is osteopathy?

The research method used to collect data to answer these research questions, was a case study. The case study design and methodology is explained through Chapter two.

Chapter 2

Methodology

2.1 Plan of investigation

As outlined within Chapter one, this was a qualitative research study that collected narrative data. This study was an investigation of health care professionalisation using the method of case study, with osteopathy in the UK, the subject of the case study.

A case study has been defined as:

'an empirical inquiry that investigates a contemporary phenomenon within its real-life context; when the boundaries between phenomenon and context are not clearly evident; and in which multiple sources of evidence are used'

(Yin, 1984, p.23)

This case study used osteopathy as an example to explore strategies and events within the professionalisation process of a health care occupational group. The data collected were selectively identified as the most likely to help answer the specific research questions which are outlined in section 1.3, and the study was divided into three parts:

Part one	Literature review
Part two	Interview data collection
Part three	Data analysis

Part one provided background data from the literature, which identified knowledge on professionalisation, the history of osteopathy in the UK with a focus on the events surrounding the Osteopaths Act 1993 and background to UK health care regulation. The literature on the events preceding the Osteopaths Act 1993, identified whom should be selected for interview within part two. Part three, data analysis, used data from the literature review to triangulate evidence and contextualise the interview data on professionalisation of osteopathy within the broader topic of health care professions.

Part one

Part one of the study, the literature review, was sub-divided into three topic areas:

- Models of professionalisation in health care
- UK health care regulation
- A brief history of UK osteopathy

The initial part of the literature review explored the topic of professionalisation in occupational groups generally, but had a focus and provided more depth on health care groups. The review then proceeded onto the history of osteopathy in the UK, then finally recognising that statutory regulation is a primary feature of a modern health care professionalisation process; the review explored literature on health care regulation in the UK.

The search for literature comprised a wide variety of potential sources. It was predicted that the material would not be limited to traditional sources, i.e. academic journals, but could be sourced from institutional libraries and organisation archives, e.g. GOsC archive. The list of sources searched during the literature review, in chronological order was:

British Library online database

Bodleian Library online database

Wellcome Library online database

Kings Fund library online database

Science Direct online database

Pub Med online database

British School of Osteopathy library

United States of America osteopathic medical school online databases

General Osteopathic Council archive

Hansard online database

The search terms used were not the traditional medical subject headings (MeSH) that would normally be used in biomedical/health science literature searches; instead were based on variations of the topics under discussion within this study:

Professionalisation:	professionalisation, legitimisation, health professionalisation, professionalism, profession.
History of osteopathy:	osteopath, osteopathy, osteopathic medicine, history of osteopathy, osteopathic, osteopathic history, osteopaths.
Health care regulation:	health care regulation, health regulation, statutory self regulation, SSR, health policy, health care policy.

Copies of sourced literature were scanned, photocopied, saved electronically or recorded as research field notes, depending on the source and nature of the material. This data was saved on file, as hard copy or electronic copy for future access during the data analysis part of the study. Some material, for example the GOsC archive, were contained in many non-catalogued boxes. In this instance, relevant data was identified and recorded as field notes.

During the literature review process, links to other potential sources of data from already sourced material were sought out and reviewed. Tracking these other potential data sources from bibliographies and text links, broadened the search of literature, providing stronger internal validity to the study.

Arguably the most significant event in the professionalisation process of osteopathy in the UK, was the establishment of The Osteopath's Act 1993. With this assumption, part two of the study, involved interviews with key players who were influential in the events preceding the Act.

Part two

Part two of the study comprised data collection from interviews with key players in the legislative process. These primary interview data formed the basis for analysis in the study. A strategy to select a sample of individuals representing different stakeholders in the legislative process was planned. The stakeholders were: osteopaths, members of parliament (MP), political consultants and the civil service. The interviewees were

contacted, invited to be participants in the study, and their consent sought. A copy of the letter providing participant information and consent forms is included as Appendix A.

The interviews were conducted by the primary investigator, McClune. It was intended to carry out interviews 'face to face' as practicable and if not possible, by telephone.

Recording of interviews was made on a digital recording device, if consent was given, and field notes were made if consent or practical difficulties prevented digital recording. This recording of the interviews enable reliable transcripts to be written, ensuring accuracy within the data collected

Interviews were planned on a semi-structured format, to ensure all relevant pre-determined questions were answered as far as possible on each topic; but also allowing interviewees time and space to reflect on the events and outcomes from a personal perspective. Semi-structured interviews should provide rich data, including personal observations and opinions, enabling some insight to the motives, interactions and personal relationships that may have been critical in the political developments.

2.2 Ethical considerations

An outline of the study was submitted to the University of Brighton Research Ethics Committee prior to commencing. The University of Brighton Research Ethics Committee accepted the study as presented, with one condition:

'an interviewee should not have to contribute financially to any costs related to an interview.'

This condition was noted and arrangements for interviews ensured this condition was adhered to. During the literature review, a second ethical issue arose regarding access to archive material. Access to the Kings Fund archive required written permission from the Chief Executive. A letter of permission was sought and received from the Chief Executive of the Kings Fund.

A third ethical issue arose with regard interviewee anonymity. Individuals identified for interviews were provided with an introductory letter, a summary information sheet of the research study and a consent form regarding appointment for interview, the use of electronic recording equipment and anonymity of interviewees within the final written thesis. The anonymity of interviewees in the data results and analysis sections of the study is dealt with by providing the interviewees with a stakeholder tag; e.g. first osteopath **(O1)**. These 'ID tags' are used throughout the data results, analysis and discussion sections of this study. This method helps to secure anonymity while allowing data analysis to have a reference point and context from which to construct a thesis. A number of influential players in the events surrounding the Osteopaths Act 1993, are identified in the public domain, and held public office; so their anonymity was not necessary during the discussion within this study, e.g. HRH the Prince of Wales.

2.3 Data analysis

The data collected within this study are narrative in format. The method chosen for data analysis, was a thematic approach. Language or narrative as data, have a number of possible methods for analysis. There are the classic research methods such as 'grounded theory' or 'discourse analysis'; or other methods which have specific theories and contexts to guide a researcher to them, such as phenomenological analysis or hermeneutic analysis (Wetherell et al., 2001).

The decision to use thematic analysis was based on the need to identify what patterns or themes were occurring within the data set, without having a predetermined theoretical model of what the data represent. For example, hermeneutic analysis is used to explore data in written narrative, particularly religious or theological material, which may be interpreted by identifying metaphor, imagery or allegory. The need for a simple and flexible method of qualitative analysis, free from any specific theory was paramount; a thematic analysis method allowed for this flexibility and was considered most appropriate (Braun and Clarke, 2006).

The literature review provided a descriptive outline of the story of osteopathy in the UK

from its origins in the early part of the Twentieth Century to recent times. These historical data focused on the happenings and events that contribute to further understanding a professionalisation process within UK osteopathy. These data identified specific individuals who were important in achieving change for the osteopathic community within the UK. The literature review was also used as a reference to triangulate the primary (interview) data during analysis and interpretation. Constant comparison between primary data and historical archive helped to verify the quality of the data (internal validity), which provided greater accuracy and reliability (external validity) in data analysis.

The thematic approach to data analysis started with the systematic reading of the data, absorbing the content, re-reading, analysing, identifying patterns within the narrative that were developed into themes. The resultant themes identified from the data, enabled a valid interpretation, that resulted in the development of a thesis. Thematic analysis is used as a method with interview data, field notes or documentary data. This form of data analysis is similar in outline to grounded theory, but does not expect the data to formulate a novel theory, merely identify themes for interpretation. A summary of Braun and Clarke's (2006, p.87) framework for thematic analysis is provided below in Table 1.

This approach to narrative data analysis is developed from the scientific philosophical concept of 'structuralism'. Structuralism asserts that any narrative will have component parts; a story and a discourse. The story represents the chronology of events, and the discourse represents what parts of the story are told and how they are presented (Hargood, 2008; Dey, 1993).

Data analysis within this study was performed using a sociological theoretical framework. This framework provided a 'sociological lens' through which the data were interpreted. A sociological theoretical approach was justified by the literature on professionalisation; which identified a profession as a social construction, which can only be fully understood within the context of social and cultural structures (Freidson, 1970, pp.302-303; 2001, pp. 4-14). The data were interpreted by reference to the literature on professionalisation, but interpretation also included reference to political data, specifically on health care policy and health care regulation.

Phase Description of the process

- 1. Familiarizing yourself with your data: Transcribing data (if necessary), reading and re- reading the data, noting down initial ideas.**
- 2. Generating initial codes: Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.**
- 3. Searching for themes: Collating codes into potential themes, gathering all data relevant to each potential theme.**
- 4. Reviewing themes: Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic ‘map’ of the analysis.**
- 5. Defining and naming themes: Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.**
- 6. Producing the report: The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.**

Table 1. Phases of thematic analysis (Braun and Clarke, 2006)

2.4 Consideration of other methodology for data analysis

Qualitative research methods are criticised for their scientific value. This criticism is generally concerned with an apparent lack of clarity, subjectivism and limited methodological or empirical rigour; concluding that qualitative research methods lack validity and reliability (Mays, 1995; Britten, 1993). Central to the criticism by empirical scientists, is that peer critical review is difficult, if not impossible due to the philosophical basis for the data analysis – the epistemological view is of constructivism and ontologically described as relativistic.

Arguably the choice of research methodology does depend on the ontological view and epistemological stance of the researcher. I would argue that the critics of qualitative research methods may not necessarily accept the philosophical stance of qualitative research. Empirical scientists are by definition, positioned within a positivist or post positivist position, and may not accept a view that knowledge can emerge from data without an a priori hypothesis. A positivist approach expects to find *truth* out in the world, setting up an a priori hypothesis and testing the hypothesis for verification [positivism] or refutability [post-positivism] (Guba, 1994; Popper, 1959).

The criticism regarding reliability and validity of qualitative data, is addressed primarily through the mechanism of triangulation. Triangulation does provide a degree of confirmability, credibility and dependability within data analysis (Wetherell, 2001, p.322). This is the qualitative equivalent of internal and external validity, reliability and objectivity claimed by quantitative data analysis methods. An open, transparent account of the study process and the individual researcher(s) potential bias; will also help to identify the risk of error.

This study collected narrative data from interview. There are a number of potential qualitative research methodologies for narrative data analysis, where narrative data comprises interview transcripts material. Grounded theory, ethnographic, content analysis and phenomenological methodologies potentially may all be appropriate when using narrative data.

However, grounded theory is a methodology to analyse data and develop a thesis based

on emerging themes from the text, it is not a methodology that allows for data analysis and interpretation using a specific theoretical framework; in this case, a sociological interpretation. Ethnography is the study of a culture or sub-culture and has certain criteria for appropriateness within a research study. Osteopathy could be thought of as a culture within the health care sector; but this study is concerned with the actions and activities by osteopaths, and others within society as a whole. An example of an ethnographic study related to osteopathy, could be the observation of the clinical encounter. A phenomenological approach is designed to study, analyse and understand human experiences. The experience of osteopathy was not an aim of this study. An analysis of patient experiences of osteopathy might be an appropriate research study that could utilise a phenomenological approach. Hermeneutics is another methodology for qualitative data analysis. This was historically used to interpret data from scripture, within theological research. Although hermeneutics has been developed further in recent years to include the interpretation of text per se; the analysis of text within this study, did not aim to describe or identify a story or message from within the narrative data. The narrative is a transcript of an interview that describes personal answers or interpretation to specific interview questions, so a hermeneutic approach would not have been helpful or appropriate.

2.5 Personal bias

I have been a practising osteopath in the United Kingdom since 1989. During my professional career I have combined clinical practice with academic research based at the Spinal Research Unit, University of Huddersfield, as well as other roles within national osteopathic organisations, e.g. GOsC member.

My research activity has had a biomedical focus, not necessarily supporting osteopathic philosophy, and has been substantially quantitative. Whilst appreciating the strengths of quantitative research methodology, it is apparent that quantitative data alone does not help to fully understand all aspects of human health. Research of human health continually provides data emphasising the social and psychological influences on individuals, alongside the biomedical influences. An emerging theme from musculoskeletal research, is that a biopsychosocial model for health is necessary to explain much of what is observed

clinically (Burton, et al., 1996, 2004; Waddell, et al., 2001). For example to understand an individual's experience of pain and disability, requires qualitative methods to collect data from that individual, exploring what the experiences the pain and disability is like. There is a limit therefore to the usefulness of quantitative data alone, on these human experiences. My desire to improve research skills using qualitative data as well as quantitative data was fundamental to my decision to embark on this study.

My other professional roles as a member of national osteopathic organisations, has provided me access to detailed and confidential information about osteopathy in the UK. This knowledge and insight to the regulatory framework of osteopathy, knowledge of the 'live' concerns regarding research, the evidence base of osteopathy and the political agenda of the Department of Health, may have caused a potential bias within this study, particularly during the interpretation of data, which followed on from data analysis.

What are my own epistemological and ontological positions?

I was not a neutral participant in this research study; the topic chosen, the theoretical model and methodology for data collection, literature review, data analysis and interpretation of data all required personal decision making and judgement. So potentially all aspects of this investigation were influenced by my experiences as an osteopath, my experience of osteopathy and my view of the world. I am aware that I needed to be fully reflective during the study process, open to bias, and honest in my communication of this bias within this thesis. Also, it may well be, that my views on the world and my views on osteopathy were changed by the study itself.

My assumptions and ideas resulting from my previous experiences, created a potential bias for the data collection and data analysis within this study; referred to as ontological relativism. The philosophical basis for qualitative research requires an acceptance that no absolute reality exists, there may be multiple realities; they are dependent on whom is doing the research; analogously this could be described as 'beauty is in the eye of the beholder'.

The qualitative data collected in this study required analysis that resulted in the construction of a reality; a constructivist approach, resulting from a constructivist

epistemology. This philosophical term describes knowledge as *created* by humans, as opposed to 'positivist' approach, that *finds* knowledge, or truth in the world. Constructivism maintains that social reality is dynamic and fluid, and that humans generate knowledge and meaning from experiences.

The following Chapter three, outlines the results of the literature review, detailing the background knowledge that provides a reference for the interpretation of the data collected during the interviews. The literature review provided not only a background to the history of osteopathy in the UK, but also identified potential interviewees from archive associated with events preceding the Osteopaths Act 1993.

Chapter 3

Literature review

The literature review comprised material that were sourced from archive in a number of institutions, electronic databases and libraries; see chapter 2.1 for a detailed description of the specific literature sources. The literature review is presented under three headings:

- 3.1 Models of professionalisation in health care
- 3.2 UK health care regulation
- 3.3 A brief history of UK osteopathy

3.1 Models of professionalisation in health care

The etymology of the word *profession*, suggests a Latin origin, coming into use within the English language from France during the Middle Ages. The original usage in English, referred to making an entrance to a religious order, first recorded about 1420, although it was not a common word. The more modern meaning relating to an occupation or calling developed as late as 1747, and more commonly during the early 1800's (Online Oxford English dictionary).

Sociological literature suggests that increased usage of the word profession was evident, from the English-speaking world during the middle of the Nineteenth Century and early Twentieth Century (Freidson, 1973). Freidson's (1970, pp.3-22) sociological analysis, suggests quite a late development of professions within modern history, occurring alongside the industrial revolution; as people migrated from rural to urban locations. This was most evident with the emergence of the medical profession, during the Nineteenth Century and into the early Twentieth Century.

Prior to the development of professions during the industrial revolution, there existed a more ancient form of such a body, established in Europe during the Middle Ages from the

Fourteenth Century onwards. This development was most obvious in the politically dominant European countries of France, Germany, Spain and Britain; and was the founding of a number of bodies called 'Guilds' (Freidson, 1970, pp.19-20). These bodies represented groups of workers under a unified title and identity, and were responsible for the regulation of the workers.

In Great Britain this role was fulfilled by the formation of the London Livery Companies. Initially twelve Worshipful Livery Companies were formed and granted Royal Charter, although eventually one hundred and seven Livery Companies were formed. Guilds responsible for healthcare workers would include; the Apothecaries, who separated from the Grocers in 1617, who had in turn been formed from the Company of Pepperers in 1428, and eventually became the guild for pharmacists. Another, the Company of Barbers, chartered as a guild by Edward IV in 1462, became a guild for the barber-surgeons in 1540, which much later became the Royal College of Surgeons in 1800. These Guilds clearly became instrumental in the development of occupational groups, and ultimately in the development of professions and their authoritative bodies, as we know them today (online London Livery Companies archive).

The study of professions and the critical social theory surrounding professions has evolved over time; with new perspectives of the role and nature of professions within society. The early dominant theory centred around the study and comparison of the three traditional classic professions of; doctors, lawyers and clergy. The early study of these centred on the characteristics of each, their 'traits', and comparison to the traits of these three, was the focus of sociological study (Dixon, 2007).

Parsons and Carr-Saunders, were both of the trait-based school; they believed that professions fulfilled a crucial role for society, with special qualities, given high regard and financial reward by society as a consequence (Parsons, 1954; Carr-Saunders, 1933). It was argued that professionals had high altruism, high moral values, and a strong sense of public service, professions held society together (Parsons, 1954, pp.34-49). Parsons went as far as saying, 'he saw professionals as the most important single component in the structure of modern society' (Parsons, 1968, p.545).

Eventually a number of trait characteristics were identified and this resulted in the Guttman

scale (Hickson and Thomas, 1973, pp.37-53):

- Professional authority over lay person
- Sanction by the community of the power and privilege of professionals
- Confidential nature of the profession-client relationship
- Shared ethical values regulating the professions
- Theoretical knowledge underlying the practice of the profession
- Existence of a professional culture – how to behave, passed on to new recruits

Medicine is the classic example of a profession developed through a trait model. Freidson (1970), suggested medicine has become the archetype profession during the Twentieth Century in Western Europe and North America; developing late as a profession, primarily a consulting profession, and now dividing specifically into a scholarly branch and a consulting branch. He describes how it has used other professions, with the specific development of science (chemistry, pharmaceutical, physics) and technology (engineering, material science) to further its knowledge base and scope of practice; bio-medicine became the dominant ideology within health care (Freidson, 1970, pp.12-22; 2001).

Freidson describes how medicine started off in the competitive world of healing with other groups, such as apothecaries, bone-setters, faith healers and herbalists during the middle ages, then managed to become the dominant and most powerful of all healing groups, fairly recently during the late Nineteenth and early Twentieth Centuries. He suggests that this development is the result of a number of strategic processes (Freidson, 1970):

- Patronage of wealthy/aristocracy/city
- Using science and technology to underpin theory and knowledge
- Control of the division of labour
- Control of Recruitment
- Association with universities
- Formation of hospitals
- Legislative achievements
- Professional construction of illness
- Medicalisation of society

- Control of scope of practice

Later in his sociological study of professions, Freidson (1970, pp.377-382) challenges the expert opinion of professionals; he claims medicine has not regulated itself well over the latter half of the Twentieth Century, allowing poor performance and self-interest to go unchecked. He claims that a consulting professional does not have expert knowledge, so others are required to oversee work and make judgments - regulation.

The trait model of professions had its critics, who pointed out the shortcomings of such a descriptive model. It has been criticised for ignoring the social and historical conditions under which the professionals have obtained status (Saks, 1986). Trait studies are also criticised for being ahistorical and atheoretical (Saks, 1986). It is claimed that 'trait' studies failed to understand how professions utilized power to achieve and defend their position (Freidson, 1970, pp.206, 303-304; 2001, pp.105-122). They has also been criticised for ignoring the potential for conflict between the client and professional (O'Donnell, 1992).

Emile Durkheim, (1982) suggested a new way of looking at society, he developed a functional methodology as a framework to study society and its divisions. He saw professions as functional parts; fulfilling necessary roles in society with reward related to the functional importance of their contribution. He also saw professionalism as a moral construct by society (Freidson, 2001, pp.38-42). Durkheim argued that social division of labour was able to happen, because society was ordered enough already (Freidson, 2001, p.41). He argued that an organic solidarity developed, with division of labour replacing old solidarity of clan, kinship and nationality. He also believed that resources for morality and ethics lay within occupations; and are not available in other modern groupings. Although he agreed that there were some pathological forms of specialisation e.g. science.

Abbott (1988) mentions that there have been four different perspectives that have sought to interpret professionalisation, a functional, structural, monopolistic and a cultural view. Abbott (1988) states that the tasks of professions are to provide expert service to amend human problems. The significant concept that has developed in the modern study of professions, is the understanding of professions 'power'.

A more critical approach looking at the power perspective of professions in society

developed during the 1970's, researchers such as Larson (1977, pp.237-244), defined professions as occupations with special power and prestige. Larson (1977) and Johnson (1972) suggested that the trait approach was functionalist, and did little to distinguish between occupations and professions. They suggested that certain professions had more power because they dealt with acute problems, where client judgement was ineffective, and they (professions) played on this uncertainty, mystification, and increasing the distance between professional and client (Larson, 1990; Johnson, 1972).

This perspective on professions and power, has resulted in the suggestions that the extent of a professions rewards were the result of the professionals exercising social control by creating protected markets (Freidson, 1970). Therefore, the test of professional status was the extent of autonomy from state control and the creation of monopolistic barriers of entry (Freidson, 1970). Although McDonald (1995), suggests the State has a crucial role in a groups professionalisation project.

Post-modern sociologist, Michel Foucault (1970, 1972), suggests that language, power and knowledge are an interconnected triad. So when a study of professions is undertaken, it may be able to identify an emerging framework of how this term has developed around language, knowledge and the resultant social and political power.

The development of professions during the Twentieth Century, for example architects and engineers, the emerging growth of paraprofessionals, for example therapists; required a more dynamic theory to explain how occupational groups became professions (Dixon, 2007, p.79).

Dixon (2007, p.79) describes how Dingwall (1999, pp.131-140) makes a distinction between demand theories of professionalisation, a process driven by occupational groups; and supply theory of professionalisation, professions being created because they serve a state interest.

Laura Empson (2007), present Director of the Cass Business School, suggests that it is possible to think that the study of professions is done, she suggests that there are some fundamental changes at present:

- De-professionalisation with client control, regulation, standardization
- Knowledge management systems
- Professional work can be performed without extensive periods of training, esoteric knowledge, it can be performed by less educated, less paid paraprofessionals
- Outsourcing work to lower paid countries
- Clients are well informed, educated, knowledgeable
- Dominance battles within a profession for power, status, wealth
- Global scale activity of some firms

3.2 UK health care regulation

Within Europe, the 'guilds' and in the UK the 'livery companies' of the City of London, developed as occupational organisations or trade associations, during the Middle Ages for many occupational groups in society, e.g. apothecaries and barber surgeons represented early medical and surgical practitioners. During the Eighteenth Century and early Nineteenth Century in the UK, health care providers existed within an open market, there was in effect a free for all; with surgeons, physicians, bone-setters, midwives, dentists, apothecaries all running their small businesses charging for their services, with no state regulation (Porter, 1989).

'The boundaries between fringe and core medicine have been contingent, fluid and negotiable...the distinction between quackery and orthodoxy is essentially social. Quacks are those doctors excluded from professional power and privilege' (Porter, 1994, p65).

The first legislative development came in the Medical Act 1858, with the state granting doctors (College of Physicians) the power to regulate themselves, 'to regulate the qualifications of practitioners in medicine and surgery' (Medical Act, 1858).

Since the Medical Act 1858, medicine has been the most powerful and dominant health care profession; then dentistry quickly followed on with legislative protection of title, after the Dentists Act 1878. The Dentist's Act 1878, was not opposed by the medical profession, dentistry was seen by medicine as a specialty of medicine, not in competition with it.

Medicine and dentistry were seen as symbiotic professions, not encroaching on each other territory, of nearly equal status (Nettleton, 1989).

During the course of the Twentieth Century, other health groups allied to medicine gradually achieved statutory regulation, much against the desires and wishes of the medical profession. Eventually midwives succeeded in obtaining their statutory regulatory body with the Midwives Act 1902 and the Nurses Registration Act was passed in 1919. Another allied health group, physiotherapists, strove to achieve statutory recognition during the later part of the Nineteenth Century; particularly after claims that their identity as masseuses was being associated with illegitimate practices such as prostitution. They eventually created a professional body, 'The Society of Trained Masseuses' in 1894 (Nicholls, 2005), and later the Chartered Society of Physiotherapists (CSP) in 1920.

The boards of the other health regulatory bodies were serviced by medical practitioners, as were a significant number of senior civil servants within the Department of Health. This complete dominance of the medical profession over all aspects of health continued up until the Conservative Government, under the leadership of Margaret Thatcher during the late 1970's (Hennessy, 1990).

The professional status of physiotherapy is particularly interesting as background knowledge for this study. Arguably physiotherapy, out of all the mainstream health care occupations, has the most similarities with osteopathy in the UK. Physiotherapy went through the professionalisation process during the latter part of the Twentieth Century with a similar model to other allied health groups. Physiotherapy developed education provision to degree level, later developing post-graduate degrees, professional doctorate programmes and professorships (online CSP website; Sparkes, 2002). Physiotherapists have a degree of autonomy from medical practitioners; but like all allied health care professions, there is an argument that they can never become fully autonomous, because their role will always remain medical in character (Freidson, 1970, p.69).

Health care regulation was reformed further with Physiotherapists, chiropodists, dietetics, medical laboratory technology, occupational therapy, radiography, remedial gymnastics, all achieving statutory regulation with the Professions Supplementary to Medicines Act 1960. The health groups regulated by legislation were all employed within the new state health

system established by Bevan in 1946, the NHS. It has been claimed that the Medical Act 1858 did not result in medical dominance, but dominance effectively resulted from the NHS Act 1946 (Eckstein, 1960), and the position of medical practitioners within the hierarchy of the hospital environment (Freidson, 1970, p.34).

The allied health care groups, although developing their professional status to a significant level, with degree courses, postgraduate degrees, professorships and university research departments; have nevertheless, remained sub-ordinate to the medical profession within the UK. This is particularly evident with allied health professionals who work within the NHS, and the hierarchy of hospital and primary care environment. Hierarchy which not only retains the medical professional as the lead clinician, but also comprises complex layers of management. There are however, opportunities for some allied health professionals to work in the private sector, which automatically ensures more autonomy for the individual (Richardson, 2000, pp.1006-25).

Alongside mainstream health care, CAM developed also through the late Nineteenth Century and into the Twentieth Century, with increasing practitioner numbers and a growing market.

The NHS in the UK was under considerable financial pressure from the 1960's onwards. Throughout the 1970's the NHS was struggling to cope financially with new developments and technology, particularly in surgical and imaging procedures. By the time the Conservative Government started in 1979, it was clear that reform of the NHS was a high priority (Hennessy, 1990; Endhoven, 1991, pp.60-64). The Prime Minister (PM), Margaret Thatcher, had an agenda for far reaching reforms throughout the public sector industries. She attempted to break up some of the old power structures; and had an objective of bringing the 'market' to areas of public life that had been within state control for generations (Hennessy, 1990). This reform within health care, was to include the increase of a role for non-medical management.

Within Whitehall, the Prime Minister brought into the civil service, Sir Derek Rayner (Marks & Spencer's Chief Executive) to set up an efficiency unit, with the primary aim of increasing management reform in the public sector. It was during the 1980's that the Conservative Government privatised many of the state controlled industries, e.g. Jaguar

1984, British aerospace 1985, British Gas 1986 and British Petroleum 1987. There were fears that Prime Minister might completely privatise the NHS (Hennessy, 1990, p.654).

During this period of Government, a series of 'Green' (Government tentative report) and 'White' (Government authoritative report) papers were introduced, proposing changes to how patient services were to be purchased and how management decisions were to be made. The desired effects of these changes were to break the old established power structure that controlled decision-making in the NHS, i.e. Medical clinicians/BMA (Hennessy, 1990, p.618). The series of reports did result in structural and legislative change for the NHS. These changes have been modified and altered on a number of occasions over the last three decades, resulting in a constant battle between professional management and medical clinicians to this day (Davies et al, 2003, pp.626-628).

Dixon, suggests that health regulation has not altered much since the original medical model of self-regulation. She suggests the principal functions remain: of setting educational standards for entry onto the register and the removal of registrants who are deemed unfit to practice (Dixon, 2007).

There have been a number of recent changes in health care legislation, resulting in new regulatory bodies:

- 1958 The Opticians Act 1958 establishes the General Optical Council (GOC)
- 1993 The Osteopaths Act 1993 establishes the General Osteopathic Council (GOsC)
- 1994 The Chiropractors Act 1994 establishes the General Chiropractic Council (GCC)
- 2001 Nursing and Midwifery Order establishes Nursing and Midwifery Council (NMC)
- 2001 Health professions Order establishes the Health Professions Council (HPC)

There has been significant change in health regulation during the last decade. These changes emerged after the criminal enquiring into Dr Harold Shipman. The 'Shipman Inquiry', chaired by Dame Janet Smith, concluded that the medical profession was not able to regulate itself and structural change was necessary within the regulation of medicine

and all other health groups. The primary changes were to increase lay involvement in the governance process and to have an independent fitness to practice structure to deal with the complaints. This intention to increase Lay involvement, was to ensure the risk of leniency by peer regulation was reduced (DH final report 2005). The Department of Health published two further papers in 2006 following the Shipman Report, relating to changes in health care regulation; for medical practitioners, '*Good doctors, safer patients*' and for non-medical practitioners, '*the regulation of non-medical health care professions – a review by the Department of Health*' (DH, 2006a, 2006b).

Other Complementary and Alternative Medicine (CAM) groups have sought legislative change. In 2000, following a House of Lords Science and Technology Report on CAM, and a further report on CAM commissioned by the Department of Health (Stone Report, 1996), a recommendation was made by the Department of Health, that some form of CAM regulatory council should be established. The Princes Foundation for Integrated Health (PFIH) invited applications from complementary healthcare groups to enter a regulation programme, which was supported by the King's Fund and the Department of Health. The groups were initially tasked with establishing single discipline professional registers (Complementary National Healthcare Council website) and in January 2008, the Complementary and Natural Healthcare Council (CNHC) was established. This is a voluntary register for CAM practitioners.

3.3 A brief history of United Kingdom osteopathy

An explanation and description of the origins of osteopathy, how it was introduced to the UK, it's early stages of development and events surrounding legislative attempts, was intended to inform the data analysis and interpretation during the discussion of the professionalisation process of osteopathy in the UK.

Osteopathy [*osteo* from the Gr *osteon* bone, *path* from Gr *pathos* suffering] (Oxford English dictionary) emerged from the United States of America during the latter years of the Nineteenth Century, developed by an American physician, Dr Andrew Taylor Still (Baer 1984, Collins, 2005). Still developed osteopathy with the vision of a complete system of

health care, which focused on the body as a self-healing unit, and the spine as the primary source of lesions leading to ill health. He believed that God had created humans as perfect beings, and that this perfect creation must have the potential to cure itself of any illness. This system of health was thought of, not as a set of laws, more of a philosophy of health with a number of defining features (Cyriax, 1975, pp.39-41; Collins, 2005):

- The body is a unit
- The body has its own self-regulating mechanism
- The body has its own self-repair mechanism
- The rule of the artery is supreme
- Structure and function are interrelated

The background of Still is uncertain. There is no evidence that Still had formal medical training, he was in effect a self-styled physician (O'Brien, 2007; Cyriax, 1975, pp.39-40). He was the son of a Methodist minister, and lived a pioneer life-style in the American 'Mid-West', with considerable freedom and necessity to adapt to the changing social and political world around him (Baer, 1984, p.717; O'Brien, 2007).

The early osteopaths were qualified medical practitioners from the USA, who also helped educate UK osteopaths in the medical subjects of anatomy, physiology, histology, embryology, dissection and bacteriology, as well as osteopathic practice and technique (Collins, 2005, p.19). A detailed quasi-medical educational background provided osteopaths the knowledge to speak a language that was on a par with the medical profession, producing a competitive environment. Osteopaths were competing with medicine in the open health marketplace, which although had statutory regulation since the Medical Act 1858, wasn't nationalised until 1948. Osteopaths were promoting an alternative health ideology which they claimed was more natural and holistic than allopathic medicine.

In the USA, schools of osteopathy were established in many States during the early half of the Twentieth Century, with particular growth from the post war years of 1950 onwards; finally resulting in full medical practice rights in all States from the 1970's (Baer, 1984,

p.717). This allowed osteopaths to practice medicine, surgery and osteopathy; essentially allowing doctors of osteopathy (DO's) the same practice rights as doctors of medicine (MD's). The success of American osteopaths' in their drive for professionalisation during the middle part of the Twentieth Century appears to have resulted from their ability to fill a void left in primary care (family health care) by allopathic doctors (Baer, 1984, p.722), a classic example of a functional model of professionalisation.

The origin of osteopathy is fairly unusual, in that one individual had the vision and energy to established a new health ideology, albeit a development of earlier similar approaches like bone-setting, or massage (Baer, 1984; Collins, 2005). The establishment of a new therapy by one individual is similar to homeopathy, established by a German physician Samuel Hahnmann in 1796, and Chiropractic by an American grocer/fishmonger Daniel David Palmer (Cyriax, 1975, p.46) in 1897.

It is clear that a similar healing practise to osteopathy, that of 'bone-setting', had been carried out within the Britain and Ireland for many years. Families often practised this healing art throughout a number of generations; indeed, it is reported that people often believed some form of inherent skill/power was passed on through the generations (O'Brien, 2007). It is likely that some form of manipulation of the spine (bone-setting) has been practised throughout human history; evidence exists from ancient Egypt and Greece (Cyriax, 1975, pp.5-14). Archive material form Britain and Ireland suggests that the practise was quite established from the Seventeenth Century in rural areas, but did not form any of the trade guilds and so was never in conflict with the other healing arts (medicine, apothecaries and barber surgeons). Often the practise was carried out in conjunction with other trades; e.g. in Cumberland with blacksmithing, in Wales with shepherding (O'Brien, 2007; Cyriax, 1975, p.29).

A synopsis of the early days of UK osteopathy from Collins (2005), suggests that by 1910, there were enough practising osteopaths in Britain and Ireland to form a professional body, the British Osteopathic Society (BOS), with twelve members attending the first meeting. By July 1911; this was to become the British Osteopathic Association (BOA), a formal wing of the American Osteopathic Association (AOA). By 1925 the British Osteopathic Association had over 50 members. The British Osteopathic Association only allowed American trained osteopaths (DO's) to become members. This division between the American 'doctors' and

UK 'osteopaths' was a divisive split, which may have been instrumental in the different identities of osteopaths today within USA and the UK (Collins, 2005).

By 1914 the British Osteopathic Association prepared a strategy to secure registration of the Association under the Companies' Act as a scientific society, with the case presented to the Board of Trade (Collins, 2005). There was opposition from the General Medical Council (GMC) and the British Medical Association (BMA), the result, the Board of Trade refused the application (Collins, 2005). This opposition from the established medical bodies in the UK, was to last throughout the Twentieth Century (Collins, 2005; O'Brien, 2007).

Osteopaths have practised their form of healing under Common Law in Britain and Ireland since their beginning at the start of the Twentieth Century (Baer, 1984, p.718). Common Law allowed individuals the right to provide health care treatment, so long as they didn't contravene any specific health legislation, such as the Medical Act 1858, or harm an individual in a criminal way, through assault or battery. Although Common law provided great freedom for osteopaths to practise in Britain and Ireland, the Medical Act 1858 had effectively given the profession of medicine the monopoly to practice surgery and medicine, and provided medicine with the power to oversee other health groups (Freidson, 1970). This monopoly of mainstream health care by medical practitioners provided osteopaths their greatest challenge; gaining acceptance from the medical, and scientific communities.

There were considerable attempts by UK osteopaths during the early years of the Twentieth Century to engage with Parliament, and a number of initiatives were taken by osteopaths to bring about legislative changes (Baer, 1984; Collins, 2005). The most significant development in the first half of the Twentieth Century was the establishment of a House of Lords Select Committee investigation of osteopathy in 1935. This created a golden opportunity, where by osteopaths could 'lay their cards on the table', in a serious attempt to achieve legislative change (Baer, 1984; Collins, 2005).

The Select Committee met on 4 March 1935. The Select Committee comprised members of the House of Lords, representatives of all mainstream health professions and academics from the basic sciences. The witnesses testified under oath; so proceedings

were as detailed and as exploratory as a serious criminal investigation. The Select Committee minutes show to what extent the antagonism existed between the established medical community, scientific community and the osteopaths. A detailed narrative and analysis of the House of Lords Select Committee proceedings of 1935 was published by Collins (2005), which paints a picture of the overwhelming opposition to an Osteopaths Bill by the medical and scientific communities (Collins, 2005). The Osteopaths Bill was withdrawn by its sponsors on 12 April 1935. On the advice of the Select Committee, a voluntary register for osteopaths, the General Council and Register of Osteopaths (GCRO) was formed on 22 July 1936.

Following the Select Committee of 1935, there was a flurry of activity to enhance the scientific basis of United Kingdom osteopathy. A leading osteopath, who had lobbied hard prior to the Select Committee and had been a key witness in the Select Committee, Kelman MacDonald and his brother George, set up a research institute in Edinburgh, the Scottish Osteopathic Research Institute, funded by the British Osteopathic Association's educational trust. The British School of Osteopathy set up the British Institute of Osteopathic Research. Both units pursued a research agenda; but there was limited progress in scientific evidence, with the profession directing most of its energy to running the newly formed voluntary register, the GCRO (Collins, 2005).

After the considerable effort and disappointment that followed the 1935 Select Committee, there was a lull within osteopathy regarding legislative activity. Events appear to have focused on the voluntary register and educational developments, with the opening of a number of osteopathic schools: A Matlock school opened and then closed between 1938 and 1947, the London College of Osteopathic Medicine (training for doctors only) opened in 1946, the British College of Naturopathy opened in 1948 and the Maidstone Osteopathic College opened in 1953. By 1964 there were 215 osteopaths registered with the GCRO, although the number of practising osteopaths would have been much higher; the GCRO was only voluntary, and required a considerable fee to be paid annually to become a member.

During 1965 a GCRO, 'status, planning and publicity committee', declared that statutory self-regulation (SSR) would not be sought, because it was thought that this would result in subordinate working practice like physiotherapy (Collins, 2005). It was to be twenty years

later when circumstances suddenly changed in favour of potential legislative progress.

'a window of opportunity'

In 1982 at the British Medical Association (BMA) 150 anniversary, HRH the Prince of Wales, spoke about the values of CAM and suggested that a BMA working party should be set up to look at CAM (Prince of Wales, 1982). This turned out to be an event which changed the path of history for osteopathy in the UK.

Another event, which turned out to be highly significant, occurred during 1983, when a leading osteopath, Simon Fielding, was co-opted as a member onto the GCRO as Parliamentary and European Economic Community Committee Chairman. His legislation brief was to lead negotiation and lobbying in Whitehall and Westminster for osteopathic support. The Committee was clear that 'to continue as an independent profession we must achieve a statutory base, and eliminate unregistered osteopaths' (GCRO minutes, 1983). Simon Fielding was to have exclusive control over parliamentary issues, anybody with information regarding political and/or legislative opportunity were to contact him in the first instance. Simon Fielding said the GCRO would be central to any Statutory Self Regulation attempts (GCRO minutes, 1983).

During 1986 Sir James Watt, President of Royal Society Medicine (RSM), invited Barry Lambert as Chairman of the GCRO, to a working party on CAM. This series of meetings was aimed at exploring the state of CAM and how possible co-operation could develop between medicine and CAM. These meetings were initially suggested by HRH the Prince of Wales in 1982 at the 150 anniversary of the BMA (Collins, 2005).

During 1987, Lord Skelmersdale (Under Secretary of State to Department of Health) said osteopaths had reached a sound basis for SSR (Hansard debate, House of Lords 11/11/87). Simon Fielding picked up on this and told the GCRO that government policy looked favourable for osteopaths' SSR (GCRO minutes, 1987).

In 1988 HRH the Prince of Wales hosted a lunch at St James's Palace, inviting two health Ministers, the Presidents of the Royal College of Physicians, the Royal College of Surgeons and the General Medical Council to encourage osteopathy to proceed with SSR.

The process that HRH the Prince of Wales suggested, was to establish a working party, possibly hosted by the Kings Fund, exploring SSR for osteopathy (Collins, 2005; O'Brien, 2007).

During 1989, it was announced that the Kings Fund would set up a working party under the Chair of Sir Thomas Bingham, to consider SSR for osteopaths. Within the terms of reference, the Working Party were to:

'have regard for the growing public demand for osteopathic treatment and increasing support, both professional and political; for early legislation and to make recommendations and report'

(Kings Fund, 1991)

The Working Party comprised: Senior osteopaths Simon Fielding, Dr John Armistead and Jane Langer; Department of Health senior civil servants; GMC representatives Sir Ian Todd and Lord Walton; Health correspondent from *'The Observer'*.

Baroness Hooper welcomed the arrival of the Kings Fund report in House of Lords debate in 1990 (Hansard). On the 3 Dec 1991, the Kings Fund held a press conference and launched its report into UK osteopathy. Present were HRH the Prince of Wales, Sir Thomas Bingham and his Working Party, the Under Secretary of State to the Department of Health, leading MPs, leaders of the medical establishment and the media.

Conservative Member of Parliament (MP) Malcolm Moss, was identified as an MP to support the Osteopaths Bill and to carry the Bill forward as a Private Members Bill. The path of this Bill through both Houses in Parliament was fairly smooth (O'Brien, 2007), and the Osteopaths Act gained Royal Assent on 1 July 1993.

The first General Osteopathic Council (GOsC) was appointed in 1996 comprising: Simon Fielding as Chairman (who had to cease being an osteopath), Nigel Clarke as vice-chairman, twelve osteopathic members (after the transition period of appointed osteopathic members, these were to be elected by registrants), eight lay members (appointed by the Privy Council), three members appointed by the Education Committee of the GOsC and one member appointed by the Secretary of State for Education. This first

Council clearly gave the balance of power to osteopaths, with an ex-osteopath as Chairman, and a potential majority of Council members as osteopaths.

The Kings Fund archive suggests that the key osteopathic players involved in the legislation process were: Simon Fielding, Jane Langer and John Armistead (Kings Fund, 1991). Dixon (2007), in her doctoral thesis, explored the regulation of complementary and alternative medicine (CAM) in the UK. Her analysis of osteopathy and the processes that lead to the Osteopaths Act 1994, suggests that 'personal policy networks' were the key mechanism through which change occurred. The key players in the policy network relating to osteopathy were; Nigel Clarke (ex-conservative research department and public policy consultant), HRH Prince Charles, Gordon Brown (Policy lead for CAM in the Department of Health), Robert Maxwell (Chief Executive of Kings Fund) Sir Thomas Bingham (Chair of Kings Fund working group on osteopathy, also a friend of Robert Maxwell), and David Tredinick (MP member of the all-party committee on CAM) (Dixon, 2007).

Dixon (2007), also establishes links between the key players involved within osteopathy and its legislative activities, to key players involved with the HRH Prince Charles, to key players involved with the House of Lords and activities surrounding health care regulation. Two people were a part of all three personal policy networks identified by Dixon (2007), Lord Walton and Nigel Clarke.

During the literature review of the history of UK osteopathy, a number of interesting features emerged from the data as the review proceeded. These interesting features are recorded below, and it is proposed that, in effect, they are early codes emerging from review of archive archive material.

Interesting features emerging from the literature review:

Ideology: Origins of osteopathy were based on religious beliefs, A.T. Still believed that God created perfect human beings, with no need for drugs. The ideology of a creationist belief system. The ideas were developed by one individual, A.T. Still. Non-scientific.

Evangelism: Early development of osteopathy in the USA relied on spreading the 'word'. A.T. Still relied on patients to spread the word of osteopathy, and the benefits that they had

received from him. Little scientific publication.

Medical/scientific resistance: Early attempts at legislative change in the UK were thwarted by the medical and scientific community e.g. BMA at the House of Lords Select Committee hearing in 1935; the conclusion was, osteopathy was not supported by scientific evidence.

Lay support (Patronage) : Patronage is identified as a core theme throughout United Kingdom osteopathy's brief history. Particularly involving non-medical Peers, and members of the Royal family. Patronage specifically for head of osteopathic organisations, e.g. president of GCRO.

Personal networks: These were used as patronage opportunities allowed, enabling effective lobbying of Parliament. Elite policy makers/Royalty, who were patients, were identified as advocates for osteopathy.

Counter culture: Social changes during the post-war years resulted in a wider usage of CAM, particularly osteopathy. This broadening use of osteopathy by society, reflected the changing social behaviour from the 1960's onwards; a rejection of the traditional social structures, an freedom to make individual choices, including health care. There was a general reduction in the power of the medical profession during this time.

Market forces: Choice within public services, and creation of the 'market'; were aspirations of the Conservative Government of the 1970's and 1980's, particularly a desire for a market within health care.

The literature review phase of this study provided a synopsis of the up-to-date knowledge on each of the three topics under review; professionalisation, health regulation and a history UK osteopathy. The narrative description of the developments surrounding UK osteopathy, recorded alongside sociological theory on professionalisation, and an outline of the broader UK health care regulation; provides contextual data within which to start the analysis of the interview (primary) data.

Chapter 4

Data

4.1 Data collection

The interviews had a semi-structured format. This format allowed for personal views and thoughts from the interviewees, but ensured that a number of predetermined questions would be answered, ensuring relevant topics were covered providing data for analysis.

The predetermined interview questions were:

1. Why did the osteopathic profession want statutory self-regulation?
2. How did the specific MP's and Lords get involved?
3. How did previous barriers like British Medical Association, General Medical Council and the Royal Colleges antipathy to osteopathy, break down?
4. How influential was the Prince of Wales?
5. What did the Department of Health think about it?
6. What strategies or lobbying was most helpful?
7. How was the General Osteopathic Council formed and why was osteopathy not added to the Council for Professions Supplementary to Medicine?
8. How was the Kings Fund Working Party set up?

During the course of the interviews, some additional questions were asked to allow for further exploration of topics as they arose naturally.

A number of key interviewees were identified by the literature review as being significant players in the events surrounding the Osteopaths Act 1993. The final list of interviewees was confirmed partly by their role and understanding of the developments leading to the Osteopaths Act 1993, and somewhat by consent to participate in the study. It was decided to try and interview at least one osteopath, one senior civil servant, one political consultant and one member of either the House of Lords or the House of Commons. The final list of interviewees were:

(O1), an experienced osteopath. O1 had been a member of the GCRO, the voluntary self-regulatory body for osteopaths, and a key player in the GCRO educational strategy process related to osteopathy and its educational institutes. This interview was carried out by telephone.

(O2), an experienced osteopath. O2 was an experienced female osteopath, a member of the Kings Fund Working Party on osteopathy and a leader within the Guild of Osteopaths. This was a detailed semi-structured interview, with full transcript recorded. I identified O2, as an individual who was the solo female osteopath and a key player in the political process leading up to the Act.

(CS1), a senior civil servant. CS1 is a civil servant, who was involved with the drafting of the Osteopaths Act 1993 and Chiropractic Act 1994. He was identified as having knowledge of the process by which the Acts became effective, and to help confirm who was involved with the final activities leading up to the Osteopaths Bill gaining Royal Assent.

(PC1), a political consultant. PC1 was a political consultant at the time of the developments surrounding the Osteopaths Act 1993. He was within the osteopathy personal network, he was a friend of HRH the Prince of Wales and was introduced to Simon Fielding by their mutual solicitor at a social engagement. PC1 later became the second Chairman of the GOsC, and had been a member of the GOsC from its inception. The interview was brief (approximately 20 minutes) and the purpose was to clarify the personal relationships within the osteopathy personal network.

(L1), a senior member of the House of Lords. L1 was a significant leader within the medical profession, he was past Chairman of the GMC, President of the BMA, President of the Kings Fund and he carried the 'flame' for the Osteopaths Act through the House of Lords.

4.2 Interview data results

The results from the interviews are described through this section within a format that corresponds to the answers of the original research questions. Key verbatim extracts are underlined.

Research question 1

What were the aspirations of United Kingdom osteopaths involved in a professionalisation process?

'there were 8 –9 different schools and societies going on none of which spoke to each other they totally shun each other' (O2) Q1

'a group of osteopaths decided that things needed to be move on (O2) Q2 things were far too lots of little groups all over the place and things were not getting anywhere with recognition or respect from outside (O2) Q3 and certainly eh eh doctors and so forth were not allowed to recommend' (O2) Q4

'during the period of the early 80's, the GCRO started to look to parliament again for legislative change. Simon Fielding (co-opted onto the GCRO) had taken the initiative, he knew Ken Clarke' (O1) Q1

'It was also significant that Simon Fielding provided treatment to Prince of Wales. (PC1) Q1 and personal discussions between Simon Fielding and Prince Charles about legislative change were common occurrences.' (PC1) Q2

' during the late 1980's a number of universities wanted to set up osteopathy courses (Manchester, Leeds, East Anglia, Kingston). (O1) Q2

'They were worried where it was going they were worried what would be expected of them um they felt that their individual identity would be lost they were concerned that there would be a big brother attitude coming in and that this would completely change their theme their ethos.' (O2) Q5

Research question 2

How did the osteopaths achieve legislative change in The Osteopaths Act 1993?

'the government came up with the idea (O2) Q6 that we could get all the different groups homeopathy chiropractic osteopaths acupuncturist made up this body and maybe we could get recognition as a group of cam.' (O2) Q7

Nigel Clarke suggested that the start of the process was the publication of a BMA report in 1985 on Complementary and alternative medicine (CAM). (PC1) Q3 The report was rubbished by a number of pressure groups and the BMA were then on the offensive. This brought the Prince of Wales to be involved with the lobbying for CAM at this particular point in time. (PC1) Q4

'we realized we were at such different standards that there was no true common denominator going through it all, osteopathy was definitely more advanced (O2) Q8, had a programme of education and so forth, even thought we were still working towards things with separate little groups and societies etc.. and they came back to us and said look this is not going the right way, we feel this is going to take far too long, probably because they were funding these meetings, the government in their opinion they felt it would be best if the osteopaths went off and did it on their own, and the others in time would follow on when they had got their education etc to an equivalent standard.' (O2) Q9

The next significant event was a lunch hosted by the Prince of Wales for 4-5 people at St James Palace. The purpose had been to confront the medical establishment, or representatives of it, with the concept that SSR for osteopathy was a very sensible option. Among those invited were; Tony Newton and Lord Walton. (PC1) Q5

'He (HRH Prince Charles) was involved with the kings fund, He prompted them to agree to fund and set up this group and see the potential of where osteopathy could sit (O2) Q10 and how it could develop and it was his encouragement, he encouraged the Kings Fund to put up the money for us to do this project (O2) Q11. Originally it was going to be a year but in fact it took a couple of years, and that was chaired by who was then called Sir Thomas Bingham.'

The setting up of the Kings Fund was key: (PC1) Q6 this again was the result of the Prince of Wales intervening (previous president), and chaired by Lord Bingham (received

osteopathy treatment). (PC1) Q7

'Prince Charles was pivotal in the process of legislative change (L1) Q1 , He actually, he was one of the initiators in the Kings Fund working party and he continued to be involved and kept a continuing interest in the process of the Bill through the House of Lords.' (L1) Q2

'The working party took evidence from many sources and eventually produced a report strongly recommending that it should move towards statutory regulation.' (L1) Q3

The Kings Fund concluded their working party with a report, which was very favourable towards osteopathy and included a Draft Bill for the next stage in the process to legislation. (PC1) Q8

Simon Fielding reportedly had an office in the DH, and working extremely closely with the DH, particularly with their team leader Andy Smith. It was suggested that Simon Fielding had great respect within the DH, and this may have helped made the process work seamlessly. (O1) Q3

'The Osteopaths Bill was given a head start in the House of Commons because the - the government wanted the Post office privatization Bill to be delayed, so the osteopaths Bill/Act was given time. He also added, that the Hedgerows Act had extra questions, so was delayed; again allowing time again for the Osteopaths Bill/Act.' (CS1) Q1

'Lord Walton was a prominent and well respected medical practitioner ; and that particularly in the House of Lords – where there were many medical practitioners - he wouldn't be challenged.' (CS1) Q2

'An important factor was that Simon Fielding was very good, trustworthy and very helpful with negotiations.' (CS1) Q3

A key DH criteria for SSR was unity, osteopathy, in his view was one of the most unified groups within CAM. (PC1) Q9

A key senior civil servant in DH was Gordon Brown. He headed up a team, part of who's

role was to look at CAM, Gordon Brown was pro CAM, and he liked (received osteopathy treatment). (PC1) Q10

'Once the draft Bill had been written by the Kings Fund working party it was easier to talk the Bill through the Lords, ' (L1) Q4

He felt that the reason the osteopaths and indeed the chiropractors didn't become part of the Council Professions Supplementary to Medicine, was that they are not only specific techniques, they are systems of medicine; ' in other words they embark not only on therapy and hence they are not just technical procedures but they are systems of medical care and practice which involve diagnostic assessment as well as therapeutic procedures' (L1) Q5

'Yes we agreed that this was not the route to take the only thing was that once we had got the bill through the act through because we were the first of the professions who were alternative at that time to get recognition then the plan would then be copied or followed on by the chiropractors ' (O2) Q12

'At this time, late 80's, the climate was driven by public opinion, (L1) Q6 as time went by, huge numbers of the population, particularly with chronic diseases like arthritis asthma and so on and particularly with chronic back pain became a little disenchanted in some respects with conventional medicine which didn't seem to have the efficacy and the cures, and of course a lot of people had heard and had learned of people, particularly with low back pain, had been cured by osteopaths and chiropractors and so the whole attitude of the public at large had changed (L1) Q7 and actually in a sense applied pressure upon government and to a degree on the medical profession to take cognisance of these particular therapies.' (L1) Q8

This was a grass roots movement, (PC1) Q11

'Because more people were using osteopaths, (CS1) Q4 SSR would help to protect the public from harm.' (CS1) Q5

Research question 3

Does the development of osteopathy in the UK follow a model of professionalisation like any other health care group?

'Yes, we agreed that this was not the route to take, the only thing was that once we had got the bill and act through, because we were the first of the professions who were alternative at that time to get recognition, other would follow.' (O2) Q13

'Well I think the reason for that was that these were or are not only specific techniques they are systems of medicine in other words they embark not only on therapy and hence they are not just technical procedures but they are systems of medical care and practice which involve diagnostic assessment as well as therapeutic procedures.' (L1) Q9

Research question 4

Does the data from investigating professionalisation of osteopathy in the UK, help to answer the broader question of, what is osteopathy?

The answers to this question, will be explored through the discussion.

The data presented through this section were analysed using a thematic approach as described in section 2.3. This analysis is detailed in the following section of this chapter, with a description of the emerging themes and potential answers to the research questions.

4.3 Data analysis

The overall aim of the study was to explore further, professionalisation of health care groups within the UK, using a case study method with osteopathy as the subject. The objective was to identify why and how the professionalisation process evolved, and contrasting this process with other health groups in the UK. The study uses the sociological concept of professionalisation as the theoretical framework for data analysis and interpretation.

The data analysis follows the thematic analysis method proposed by Braun and Clarke (2006), described in detail within section 2.3, from phase one to six.

Phase 1

The literature review exploring the history of UK osteopathy, section 3.3, highlighted a number of interesting features. These features were recurring themes within the literature, and have been given an identity, to help with data analysis and the interpretation of primary data within the context of the history of UK osteopathy. The interesting features were identified as:

Ideology

Evangelism

Medical resistance to osteopathy

Lay support

Personal networks

Counter culture

Market forces

Phase 2

The initial interesting features identified from the literature review, were then used to develop coding and categories from the primary interview data. The verbatim quotes that were given as answers to the research questions, recorded in section 4.1, were then carried over into phase 3 of the analysis, for the identification of categories.

Phase 3

The verbatim quotes were analysed within the context of the interesting features that emerged from the literature review, and potential categories were identified. This process involved reviewing the verbatim quotes within the context of both the research questions, and the interesting features from the literature review. This process produced seven categories:

Legislative change

Medical recognition

Osteopathic expansion

Prince of Wales

Simon Fielding

Patronage

Social change

These categories were then carried over into phase 4.

Table 2. Interesting features of the literature review developed into categories from the primary interview data and the supporting verbatim extracts.

Interesting features from literature review	Categories from interview data	Verbatim extracts
Medical resistance to osteopathy	Legislative change	<p><i>there were 8 –9 different schools and societies going on none of which spoke to each other they totally shun each other (O2) Q1</i></p> <p><i>a group of osteopaths decided that things needed to be move on (O2) Q2</i></p> <p><i>things were not getting anywhere with recognition or respect from outside (O2) Q3</i></p> <p><i>doctors and so forth were not allowed to recommend (O2) Q4</i></p> <p><i>Simon Fielding (co-opted onto the GCRO) had taken the initiative, he knew Ken Clarke (O1) Q1</i></p> <p><i>the government came up with the idea (O2) Q6</i></p> <p><i>maybe we could get recognition as a group of CAM (O2) Q7</i></p>
Medical resistance osteopathy	Medical recognition wanted	<p><i>things were not getting anywhere with recognition or respect from outside (O2) Q3</i></p> <p><i>doctors and so forth were not allowed to recommend (O2) Q4</i></p>

Counter culture	Osteopathic expansion	<p><i>One interviewee explained that during the late 1980's a number of universities wanted to set up osteopathy courses (Manchester, Leeds, East Anglia, Kingston) (O1) Q2</i></p> <p><i>At this time, late 80's, the climate was driven by public opinion (L1) Q6</i></p> <p><i>the whole attitude of the public at large had changed (L1) Q7</i></p> <p><i>This was a grass roots movement PC1 Q11</i></p> <p><i>Because more people were using osteopaths (CS1) Q4</i></p>
Lay Support Personal networks	Prince of Wales	<p><i>It was also significant that Simon Fielding provided treatment to Prince of Wales (PC1) Q1</i></p> <p><i>personal discussions between Simon Fielding and Prince Charles about legislative change were common occurrences (PC1) Q2</i></p> <p><i>This brought the Prince of Wales to be involved with the lobbying for CAM at this particular point in time (PC1) Q4</i></p> <p><i>The next significant event was a lunch hosted by the Prince of Wales for 4-5 people at St James Palace (PC1) Q5</i></p> <p><i>He (HRH Prince Charles) prompted them to agree to fund and set up this group and see the potential of where osteopathy could sit (O2) Q10</i></p>

		<p><i>He (HRH Prince Charles) encouraged the Kings Fund to put up the money for us to do this project (O2) Q11</i></p> <p><i>the result of the Prince of Wales intervening (previous president), and chaired by Lord Bingham (received osteopathy treatment) (PC1) Q7</i></p> <p><i>Prince Charles was pivotal in the process of legislative change (L1) Q1</i></p> <p><i>He actually, he was one of the initiators in the Kings Fund working party (L1) Q2</i></p>
Personal networks	Simon Fielding	<p><i>Simon Fielding (co-opted onto the GCRO) had taken the initiative, he knew Ken Clarke (O1) Q1</i></p> <p><i>It was also significant that Simon Fielding provided treatment to Prince of Wales (PC1) Q1</i></p> <p><i>Personal discussions between Simon Fielding and Prince Charles about legislative change were common occurrences (PC1) Q2</i></p> <p><i>Simon Fielding reportedly had an office in the DH, and working extremely closely with the DH, particularly with their team leader Andy Smith. Greg Sharp suggested that Simon Fielding had great respect within the DH, and this may have helped made the process work seamlessly (O1) Q3</i></p> <p><i>An important factor was that Simon Fielding was very good, trustworthy and very helpful with</i></p>

		<i>negotiations (CS1) Q3</i>
Lay support Personal networks	Patronage	<p><i>Simon Fielding (co-opted onto the GCRO) had taken the initiative, he knew Ken Clarke (O1) Q1</i></p> <p><i>It was also significant that Simon Fielding provided treatment to Prince of Wales (PC1) Q1</i></p> <p><i>Personal discussions between Simon Fielding and Prince Charles about legislative change were common occurrences (PC1) Q2</i></p> <p><i>The next significant event was a lunch hosted by the Prince of Wales for 4-5 people at St James Palace (PC1) Q5</i></p> <p><i>He (HRH Prince Charles) prompted them to agree to fund and set up this group and see the potential of where osteopathy could sit (O2) Q10</i></p> <p><i>He (HRH Prince Charles) encouraged the Kings Fund to put up the money for us to do this project (O2) Q11</i></p> <p><i>the result of the Prince of Wales intervening (previous president), and chaired by Lord Bingham (received osteopathy treatment) (PC1) Q7</i></p> <p><i>Prince Charles was pivotal in the process of legislative change (L1) Q1</i></p> <p><i>He actually, he was one of the initiators in the Kings Fund working party (PC1) Q2</i></p> <p><i>A key senior civil servant in DH was Gordon Brown.</i></p>

		<p><i>He headed up a team, part of who's role was to look at CAM, Gordon Brown was pro CAM, and he liked (received osteopathy treatment) (PC1) Q10</i></p>
<p>Counter culture Lay support</p>	<p>Social change</p>	<p><i>During interview it was explained that during the late 1980's a number of universities wanted to set up osteopathy courses (Manchester, Leeds, East Anglia, Kingston) (O1) Q2</i></p> <p><i>The Kings Fund concluded their working party with a report, which was very favourable towards osteopathy and included a Draft Bill for the next stage in the process to legislation (PC1) Q8</i></p> <p><i>At this time, late 80's, the climate was driven by public opinion (L1) Q6</i></p> <p><i>the whole attitude of the public at large had changed (L1) Q7</i></p> <p><i>in a sense applied pressure upon government and to a degree on the medical profession to take cogniscence of these particular therapies (L1) Q8</i></p> <p><i>This was a grass roots movement (PC1) Q11</i></p> <p><i>Because more people were using osteopaths (CS1) Q4</i></p>

Table 2. Interesting features of the literature review developed into categories from the primary interview data and the supporting verbatim extracts.

Phase 4

The categories (Legislative change, Medical recognition, Osteopathic expansion, Prince of Wales, Simon Fielding, Patronage, Social change) were reviewed again, cross referenced with the literature review features (Ideology, Evangelism, Medical resistance, Lay support, Personal networks, Counter culture, Market force). This cross referencing checked for inconsistencies within the data set, an example of triangulation, which provided a greater level of internal validity to the study. A thematic map was constructed, to help identify the possible emerging higher level themes from the categories already established during phase 3 and incorporating the 'interesting features' from the phase 1 of the data analysis.

Phase 5

The higher level themes were then identified, defined and named. The naming of the themes developed from a point of view that: the themes should best describe the collation of categories, that have have been identified within the context of interesting features that were noted from the literature review. Figure 1. presents the development to the higher themes which occurred during data analysis.

The higher level themes which emerged from the categories were:

Status

Relationships

Market.

Interesting features

Ideology
Evangelism
Medical resistance
Lay support
Personal networks
Counter culture
Market force



Categories

Legislative change
Medical recognition
Osteopathic expansion
Prince of Wales
Simon Fielding
Patronage
Social change



Themes

Status

Relationships

Market

Figure 1.

Status

The literature review clearly identified an ongoing desire, if not exactly a clear strategy, by osteopaths in the UK to achieve more recognition from statutory authorities and to enhance their professional status within health care. These desires ranged from developing osteopathic associations and establishing training schools, to attempts at legislative change. An example of organisational change was the BOA's attempt to secure registration of the Association under the Companies Act during 1914, which resulted in opposition from the GMC and the Board of Trade refused. Again a year later, in 1915, an attempt was made to incorporate the BSO, this was refused; the reason given was the commencement of World War I.

Legislative change was initiated In 1924, when the Osteopathic Defence League (ODL) set up by Dr Wilfrid Streeter, an American osteopath, aspiring to bring legislative change and put osteopathy on an equal footing with medicine. This was supported by Arthur Greenwood MP, with a campaign presenting hundreds of signatures. A year later in 1925, Arthur Greenwood asked the Prime Minister to look at the Medical Act and draw up an Osteopathy Act. During 1930, Cyril Atkinson MP, was given permission to present a draft Bill to enable statutory registration. This draft Bill was stalled, and the draft Bill was reintroduced by Robert Boothby MP in 1934. On 11 December 1934, the Bill had a second reading in the House of Lords from Viscount Elibank, and was then passed on to a select committee stage. The high point of these attempts to raise the status of UK osteopathy, and achieve legislative change, was the achievement of securing a House of Lords Select Committee hearing in 1935. There were numerous other, less committed attempts over the decades following this event in 1935, until the events leading up to the final achievement of legislative change, with the Osteopaths Act 1993.

These attempts by osteopaths during the early decades of the Twentieth Century to raise the profile and status of osteopathic organisations, schools and public image, are typical of an occupational group's attempt to professionalise. These early attempts have been described by Baer (Baer, 1984), as an attempt by British osteopaths to obtain a monopoly of manipulative therapy, which Baer describes as typical of health occupational groups actions as proposed by Krause (Krause 1977, p.74):

'a series of strategies intended to increase the prestige of the occupation'.

Baer suggests in the mid 1980's, that osteopaths in the UK could be described as a 'marginal profession', similar in status to chiropractic in the USA (Baer, 1984, p.723). This evidence of inadequacy and insecurity, is reinforced by comments made during interviews in this study, when an osteopath who was also a member of the Kings Fund Working Group on Osteopathy, described the process during the 1990's as a strategy to raise the profile of osteopathy ensuring more medical referrals and protecting the title of osteopathy **(O2 Q2, Q3, Q4)**.

There was considerable opposition to osteopathic thinking, seen in its starkest form at the House of Lords Select Committee during 1935. The motivation for change throughout the Twentieth Century, appears to be that osteopaths wanted to prove to the statutory authorities, and ultimately the established medical profession, that they were a legitimate health profession in their own right. The overarching emphasis, was that osteopathy offered an alternative to medicine in the treatment of many health problems. There was a desire to secure osteopathy's future, increase referral rates from medical practitioners and establish osteopathy as a legitimate health profession **(O2 Q2, O2 Q3, O2 Q4)**.

The GCRO had aspirations to enhance the status of osteopathy with legislative change, enabling protection of the title osteopath and increasing the professional and social profile of osteopathy; with the possibility of getting osteopathy purchased by the NHS (GCRO minutes, 1975-1988). They employed an educational standards officer in 1975, and they suggested that 10000 members were needed to be a viable profession, their 25 year plan. The GCRO co-opted Simon Fielding onto the Council in 1983. In 1986, the GCRO gave Simon Fielding the Legislation Brief (Parliamentary and EEC liaison Committee Chairman). He was given the authority to go for Statutory Self Regulation (SSR), with specific instructions that all activity surrounding the issue was to be controlled by Simon Fielding (GCRO minutes, 1986).

Simon Fielding made a statement in November 1986; stating that the government accepted different therapies were at different levels of education, and that it was clear over the last few years that to continue as an independent profession, osteopaths must achieve

a statutory base and need to eliminate unregistered osteopaths (GCRO minutes, 1986). A parliamentary advisor suggested to the GCRO that a Private Members Bill, was most likely to succeed (GCRO minutes, 1986).

The evidence from this study suggests that not all osteopaths or osteopathic groups were happy with the thought of statutory registration. The educational institutes in particular were concerned about the extra demands and expectations that could be put on them. They were concerned that they would lose their autonomy, and that mainstream universities would establish courses, creating competition, and potentially threatening their existence (**O1 Q1, O1 Q2, O2 Q7**). The osteopathic community had existed so far, independent of the state, it had developed and grown, and arguably many individuals were content for that independence to continue.

There was a clear rejection by osteopaths to the option of joining the Council for Professions Supplementary to Medicine (CPSM), which was accepted by the Kings Fund working party (Kings Fund, 1991). The osteopaths interviewed described that within the Kings Fund working group activities, there was a suggestion that the osteopaths could have become regulated with the CPSM or unite with chiropractors to form a single regulatory council. Both these options were rejected by the osteopaths involved in the process. (**O2 Q13, L1 Q5 Q9**) and upheld by the working party.

Relationships

The literature describes how UK osteopaths sought high profile advocates to head their various organisations and educational institutes. A list of the presidents of the voluntary register of osteopaths, the GCRO, is helpful when making this point: Lord Elibank, Lord Strabolgi, Earl of Mansfield, Viscount Bledistow, Air Chief Marshall Sir William Elliot, Earl Jellicoe, Earl De La Warr. The Patron of the BSO has been HRH Princess Anne since 1983. The Patron of the GOsC has been HRH the Prince of Wales since 1997 (Collins, 2005). The relationships with strategic elite groups in society, including policy makers, is evidence of the high social status osteopaths' networks comprised. The GCRO had access to policy makers through the personal networks of senior osteopaths, giving power to any

attempt at legislative change.

Although a heterogeneous group, osteopaths in the UK had a dominant public voice, the GCRO, comprised of osteopaths educated from the BSO (Collins, 2005). The BSO, an osteopathic educational institute; was the largest, most high profile, and most medically orthodox with respect to health ideology (Collins, 2005). During the 1980's, the number of students training as osteopaths increased significantly, and the educational institutes became more standardised in their curricula, with the BSO leading the educational changes by attempting to develop its diploma course to a degree course, validated by the CNAA . The BSO employed Sir Norman Lindop as its principal (1982-1990). Norman Lindop was a well respected educationalist who had carried out a review and project to establish the 'polytechnics'; and amongst other appointments, was a lay member of the GMC, which provided the BSO and osteopathy a powerful voice with strategic elites, policy makers (Baer, 1984, p.723). The BSO had a clear aim to establish degree level osteopathic training, which was then followed by the European School of Osteopathy (ESO) and the British College of Osteopathy and Naturopathy (now British College of Osteopathic Medicine).

The GCRO launched a major lobbying campaign, 300 osteopaths lobbied their constituency MP's, seeking their support in legislative change (Collins, 2005). The president of the GCRO at the time, Earl de la Warr (personal network of Maurice Hills, a GCRO member), introduced the GCRO members: Simon Fielding, Maurice Hills and Barry Lambert, to Baroness Trumpington, in order to help with the desired legislative process. This is evidence of personal networks being utilised for political gain.

During this time, it was most helpful for UK osteopaths, that HRH the Prince of Wales became interested in the drive to gain further recognition for CAM. He was a patient of Simon Fielding, and as detailed later in this chapter, he played a pivotal role in the process of osteopathy gaining legislative change (**PC1 Q1, PC1 Q2**).

The Department of Health had helped to establish a series of meetings with a 'CAM working group' set up by the RSM. However, there is evidence that this didn't make much progress and soon began to stall. It was reported during interview that at this stage the Department of Health recognised osteopathy had made much more progress with its

educational basis and other professional developments, and it was suggested that the osteopaths were encouraged to '*go it alone*' to progress with their legislative aspirations **(O2 Q8, O2 Q9)**.

The next significant event in the process of legislative change, and the aspiration of raising the status of osteopathy, was a lunch hosted by HRH the Prince of Wales at St James Palace. Simon Fielding was the osteopathic representative **(PC1 Q5)**. The outcome of this luncheon event, was the establishment of the Kings Fund Working Party on osteopathy, chaired by Sir Thomas Bingham. HRH the Prince of Wales was the president of the Kings Fund, Lord Walton a previous president, and it appears that their influence was significant in establishing the 'working group'. The Kings Fund involvement was a very substantive part of the process. The working group was set up, comprising representatives of the Department of Health, the medical profession, the GMC, osteopathy (Simon Fielding, Jane Langer, John Armistead) and a health journalist **(O2 Q10, O2 Q11, PC1 Q6, PC1 Q7, L1 Q1, L1 Q2)**.

The Kings Fund working group went through a thorough consultative process with osteopathic representatives, medical representatives, regulatory bodies, educational bodies, other non-medical health professions and consumer groups. Finally it published its finding in 1991(Kings Fund, 1991); recommending the establishment of the GOsC, a draft Bill was attached to this report, to aid further development **(L1 Q3, PC1 Q8)**.

The setting up of the Kings Fund working group on osteopathy was able to happen because of the intervention of HRH the Prince of Wales and the personal networks that he was involved in. These personal networks involved osteopaths. It is of interest that the Kings Fund working group composition was weighed heavily in favour of osteopaths. This is in stark contrast to the Select Committee of the House of Lords in 1935, which had no osteopaths as members, but who members cross-examined osteopaths evidence. It is of further interest, that the Chair of the Kings Fund working group was a service user of osteopathy.

Th usage of osteopathy by high profile individuals, policy makers, MP's and members of the Royal Family appears to be crucial in the process of UK osteopaths achieving their aims of statutory recognition. Personal networks involving Simon Fielding (Dixon, 2007)

and Maurice Hills (GCRO minutes), among others, provide links and contacts with the policy makers.

These personal networks also achieved a significant feat in overcoming the very real historical barrier to legislative change - medical and scientific opposition to osteopathy.

Legislative change was the aspiration of a few elite osteopaths and the GCRO. To help their case a number of other professional developments were taking place; educational standardisation (Collins, 2005; **O1 interview**), a research strategy working party was established by the BSO in 1982, then a GCRO research group was established in 1994 (Collins, 2005). There was an attempt during the 1980's and 1990's to present a united and forward thinking (modern) health group (Baer, 1984; **O2 interview**).

Briefly mentioned earlier in this chapter was the importance of personal networks that some elite osteopaths were involved with. It is proposed that these personal networks facilitated the process of legislative change more than any other influence. There were some organisation changes with respect to education, ongoing (apparently respected and successful) voluntary registration and regulation with the GCRO, expansion in number of osteopaths and an attempt to raise the profile of research and science within and without UK osteopathy (Baer, 1984; Collins, 2005; GCRO minutes). These influences arguably were all very helpful in the process of achieving legislative change, but it is proposed the personal networks (relationships) were the most influential.

The archives of UK osteopathy regularly name individuals - almost triumphantly - from the elite social groups (aristocracy) that were receiving osteopathic treatment; providing evidence of successful social as well as client based (professional) relationships. It is evident that UK osteopathy used this 'patronage' of these individuals; Lord Jellicoe, Viscount Elibank (both involved with supporting osteopathic legislation in the House of Lords), Lord Cullen of Ashbourne (chairman of Osteopathic Education Foundation), Earl de la Warr (president of the GCRO), Lord Walton (supported Osteopaths Bill through the House of Lords) and HRH the Prince of Wales (catalysed relationships between osteopaths, the Kings Fund and the medical establishment) played a very significant role in the professionalisation process of UK osteopathy.

Dixon's (2007) policy network map for osteopathy circa 1983-1993 included; HRH the Prince of Wales, Simon Fielding, Thomas Bingham, Nigel Clarke and Lord Walton. Her (Dixon, 2007) policy network map for HRH the Prince of Wales circa 1997 included; Simon Fielding and Julie Stone (Present GOsC member). Her (Dixon, 2007) policy network maps for the House of Lords and regulatory Working Groups, circa 2000 and 2003 respectively included; Simon Fielding, Lord Walton, Julie Stone and Nigel Clarke.

This importance of the personal networks was further highlighted by the results from the interviews in this study (**PC1 Q1, PC1 Q2, PC1 Q7, PC1 Q10, O1 Q1**). From the evidence it is suggested that without these personal networks, the development of the events which paved the way for the Osteopaths Act 1993 would not have happened. The suggestion from Baer (1984, p.723) after his analysis of the professionalisation process of UK osteopathy during the 1980's, may well have been correct 'for the foreseeable future the Conservative government is unlikely to grant statutory recognition to osteopaths', had not the senior office holders of osteopathy not developed these personal networks.

The personal networks, although arguably crucial for events to have occurred at all, at this time; required other circumstances to be favourable. The political climate needed to be 'open' to the possibility of private healthcare providers being further recognised or regulated by statute. This point is made during interview by a senior civil servant involved in the process who suggested that it is doubtful if a Labour Government would have been quite so helpful in the process. This is supported by the political aspirations of the Government during the 1980's to privatise many previous public owned companies, e.g. British Petroleum, British Airways, British Rail.

Market

There had been considerable opposition from the medical profession and scientific community throughout the Twentieth Century to osteopathy gaining legislative change. This is seen in stark reality during the House of Lords Select Committee investigation of osteopathy in 1935 (Collins, 2005). As with all non-medical health groups, osteopaths were in competition and attempting to gain autonomy from medicine. These aspirations have

been at the heart of all health groups professional activity throughout the Twentieth Century, and indeed to the present day (Freidson, 1970; Dixon, 2007). Medicine was the controlling group within healthcare, and oversaw allied health groups and nursing. Medicine had a powerful voice in Parliament, with numerous MP's and Peers, having a medical background. Medicine controlled the market, they had a monopoly.

Osteopathy in the UK had some advantages over other health groups. Osteopathy has always existed on the outside of the mainstream health service, and so didn't have the same hierarchical structures and controlling influences that the medical profession maintained in hospitals and community health services. In effect, there were no doctors telling osteopaths what to do. This was only possible of course, because of the liberal effects of Common Law in the UK, and the lack of specific regulations beyond the various health Acts limiting certain practices. It could be argued that osteopathy existed in a relatively 'open' market, which allowed them to develop their own 'brand' or identity, and indeed they did this with considerable success.

Although osteopathy was identified as a single health group, or in the language of today, a single 'brand' or service; there is evidence that in fact osteopathy in the UK was really quite a dis-unified group of healthcare practitioners up until the voluntary register, the GCRO, was established in 1935 (Collins, 2005). The GCRO registered about 70% of UK osteopaths. There were then a number of smaller registers or associations. These dis-united and fragmented groups appeared to have different ideas about what direction the profession should take. This point was made clear during an interview for this study (**O2 Q1**). There is also evidence from the House of Lords Select Committee in 1935, that there were different factions within osteopathy, and although they tried to work together during the 1935 events, their disunity was clearly evident (Collins, 2005).

This lack of official recognition from the medical profession and basic scientists was a consequence of a lack of scientific evidence to support osteopaths diagnostic and therapeutic claims (Collins, 2005; O'Brien, 2007). There was little research activity and little evidence to back up the osteopathic theory and treatment proposed by osteopaths. The medical profession and other basic scientists were not impressed; this is particularly evident when reviewing the evidence from the House of Lords Select Committee hearing in 1935 (Collins, 2005; O'Brien, 2007).

This opportunity at the Select Committee in 1935 failed because the scientific and medical community challenged the intellectual substance of osteopathic ideology and practice; and judged that the evidence put forward for osteopathy as a legitimate and alternative, or complementary form of medicine, was not sufficiently robust for statutory support (Collins, 2005; O'Brien, 2007). The medical profession at that time had complete control over its own practice rights, and also control over all other health care groups. If the medical profession judged that osteopathy was not scientifically sound, then that was the end of it.

Under Common Law, there was no mechanism to stop the practise of osteopathy in the UK - unlike some other European countries, with different legal systems. So osteopaths were guided after the Select Committee Hearing in 1935, to establish a voluntary register. The voluntary register, the GCRO, operated very successfully from its inception in 1936 until the transition and transfer of assets to the statutory register, the GOsC in 1997.

At the time of the events preceding legislative change for osteopathy in 1993, a Conservative Government was in power, with Mrs Thatcher as Prime Minister. The health policies at this time were focussed on introducing the internal market to the NHS, and breaking the medical professions power on the NHS (Hennessey, 1990; Endhoven, 1991), consumerism, and the establishment of an internal 'market' within the NHS, was gathering momentum. During interviews, **(CS1)**, suggested that a different political climate may have been less helpful in the process of osteopaths gaining legislative change. He was doubtful that a Labour government would have been quite so keen on either the Osteopaths Act or Chiropractic Act, because of the issue of private medical care, and a fee charged.

The significant events that preceded the Osteopaths Act 1993 occurred during the late 1980's, within a very different political landscape; a time when Government ideology was firmly focussed on privatisation and introducing the market to public industries, particularly health care (Hennessey, 1990). As well as the changing political climate, social changes had swept through the UK since the ending of the Second World War.

Alternative lifestyles and attitudes were permeating society at all levels. Individuals could make choices about how they lived their lives, like never before. One effect of this freedom, was the expansion of CAM from the 1960's. This choice to seek alternative health care resulted in a much wider usage of osteopathy across social groups,

osteopathy was no longer just for the benefit of social elites. This point was raised during interview within this study by three of the interviewees (**L1 Q1 Q7 Q8, PC1 Q11, CS1 Q4**).

These changes to social behaviour and cultural ideas, helped to break down a barrier that historically had stopped osteopaths gaining support from the established medical and scientific communities. The complete dominance of health care by the medical profession was no longer accepted. It is clear that the scientific basis of osteopathy was not rigorously explored again or challenged by the policy makers, nor the Kings Fund Working Group, in quite the same detail as in 1935 (Kings Fund, 1991). There was no Parliamentary Select Committee investigation of evidence. The Kings Fund Working Group was tasked to 'provide a practical means of achieving regulation for the benefit and protection of patients' (Kings Fund 1991, p.iii). This was in effect more of a consultation process with stakeholders, consumer representatives and spokespersons for the medical profession and Department of Health; rigorous analysis of scientific evidence supporting osteopathy does not seem to have taken place within the Kings Fund working party. The composition of the Committee, given the power to make judgement and provide recommendations to Parliament, was also very different from the 1935 Select Committee; three osteopaths were actually members of the Kings Fund working party. They did review evidence from a wide variety of sources, but the critical cross-examination that was evident in the House of Lords Select Committee in 1935, was not part of that process (Kings Fund, 1991). There are clear differences between the 'official' investigation of osteopathy in 1935 and 1991. These differences help to describe why osteopathy was successful in achieving legislative change after the 1991 investigation.

Summary

Both the 1935 and 1991 investigations were initiated by UK osteopaths. The investigations were the end result of a process of lobbying within Parliament combined with securing support from key individuals and policy makers, good evidence of osteopaths making use of their considerable patronage. Arguably the support from key individuals in 1991, particularly HRH the Prince of Wales, achieved a significant advantage beyond what was possible in 1935. The significant advantages resulted in three senior osteopaths being

appointed onto the Kings Fund working party. The Kings Fund Working Party was independent of Parliament and the Kings Fund is highly respected by the Department of Health and Parliament. This respect of the Kings Fund from the legislative authorities, provided osteopaths with an opportunity to influence Parliament, that was not possible in 1935. The social changes that resulted in osteopathy being widely used in society, appears to have been a primary reason for investigating the possibility of legislative change at all.

The political energy for recent change appears to be an ideological basis of developing a regulated market, rather than a free market. A regulated market proposes to protect the interests of consumers, by encouraging competition and raising standards of excellence, whilst ensuring a level of governance. With both the traditional and more recent sociological concepts surrounding professions, professionalism and professionalisation in mind; the data analysis within this study will be interpreted and discussed here.

It is of interest that osteopaths perceived the creation of a statutory regulatory body as proof of their professional status; while the authorities identified the need to protect the public and ensure high quality osteopathic care.

Phase 6

Discussion of the data analysis is described through Chapter 5, the discussion focusses on the contrast of professionalisation of UK osteopathy and other health care groups.

Chapter 5

Discussion

The study of the workplace, the division of labour and their social consequences have been a subject of academic endeavour by sociologists since the mid Nineteenth century, particularly literature from Marx (1867), Durkheim (1893) and Weber (1905). Sociological analysis of the specific group of workers, the professions, became a subject of study during the early Twentieth Century, particularly by sociologists; Parsons, Carr Saunders, Wilson, Foucault and later in the Twentieth Century by Freidson, Larson, and Abbott. The early literature on professions focussed on a systematic analysis of what a profession was (definition), what groups could be called a profession (categorisation) and how professions developed (professionalisation). This obsession of definition, categorisation and development has been challenged in recent sociological literature; with comment and reference to data describing the new concepts of de-professionalisation and professionalism (Larson, 1979, Clark, 2005, Freidson, 2001).

Recently, Laura Empson, Director of the Cass Business School, suggests that it is possible to think that the study of professions is complete, suggesting that we know their distinctive traits (monopolistic claims to expertise and ethics), we recognize what they are trying to achieve (power, status, wealth), and we understand the system with which they work to maintain their power base (Empson, 2007). Historically professions had considerable control over their activities and futures, unencumbered by legislative oversight. This freedom has been broadly removed over recent years in the UK, with changes to legislation affecting both health and non-health professions; resulting in less autonomy and more regulation; seen respectively in the changes to the GMC following the Shipman Enquiry and the publication of 'Good Doctors, Safer patients' (Department of Health, 2006a) and changes to the Law Society permitting non-legal management of law firms from October 2011 (Legal services Act 2007)

This study provides data which describes the process of how a specific group of health care workers in the UK, osteopaths, attempted to enhance their professional status, initially competing against the established, dominant health profession of medicine; finally

using all means and networks at their disposal to effect legislative change.

The achievement of securing legislative change resulted from a variety of influences and circumstances coming together at one particular point in time – 'a window of opportunity'. Social changes resulting in wider usage of osteopaths, combined with the usage and perception of 'worth' within strategic elites (policy makers); at a time when Government policy actively sought for the 'market' to be established into the NHS, all helped to persuade policy makers of the need for legislative change. This opportunity was taken up by a senior influential osteopath, Simon Fielding, who had a personal network which included HRH the Prince of Wales, enabling Royal support to persuade the Kings Fund to establish a working party to 'devise a practical means of achieving regulation for the benefit and protection of patients' (Kings Fund, 1991).

These elite policy makers became involved in the legislative process primarily because of their personal experience of osteopathy and their personal networks that included a few senior osteopaths. The energy and determination of Simon Fielding, combined with his personal network, enabled significant political progress, resulting in previously rigid barriers from the medical and scientific communities being removed. It is pertinent that three senior osteopaths were members of the Kings Fund working party, evidence of a shift of power resting within osteopathic hands, power which historically rested with the profession of medicine.

Legislative change resulting in a legal monopoly is often quoted as an essential component of professional status (Carr-Saunders and Wilson, 1933). The early osteopaths in the UK were medical practitioners from the USA, who arguably held a high professional status within that society. There is substantial evidence that a professional status may have been granted by lay people and patients; but not by other professionals and in particular, not by medical practitioners. Evidence of support was the usage of osteopaths by elite groups in society - aristocracy and the Royal Family. These elite members of society rewarded osteopaths with their patronage to osteopathic schools e.g. the BSO, and organisations e.g. the GCRO. There was also considerable support from MP's and Peers. This patronage within the Palace of Westminster, Aristocracy and the Royal Family was called upon in the final attempt to achieve legislative change with events preceding the Osteopaths Act 1993. Freidson suggests 'the professionalisation of an occupation

depends on its appeal to strategic elites in the larger society' (Freidson, 1970, p.72), and Baer suggests that 'if competing health occupations find support among political, economic and social elites, they may be able to make inroads upon the professional dominance of medicine' (Baer, 1984, p.722). Osteopaths in the UK successfully utilised the patronage which resulted from their relationships with strategic elites to finally achieve legislative change in 1993.

So is osteopathy in the UK a modern health care profession?

Social scientists have suggested an ideal type (Freidson, 1970, pp.71-84), in order to provide a reference point to compare how well a group has progressed in reaching the goal of 'profession'. A list of what would be expected features of a profession - an ideal type - is presented in Table 3.

Table 3. An ideal type profession

Expected features of a profession	Present in osteopathy
Monopoly	Partly, osteopathy is a protected title, but treatment (spinal manipulation) provided by osteopaths can be provided by other health professionals also, e.g. physiotherapists.
State authority with exclusive resources	No
State regulated	Yes, Statutory regulation in the UK by GOsC.
Determine standards and educational requirements	NO, GOsC determines these.
Code of ethics	Yes, Code of Conduct and Standards.
No authority from other health professions	No
Authority over other health professionals	No
Control over referrals	No
Control over non-health benefits e.g. sick-note, pension	No
Over representation in policy bodies	No

Ideological dominance over others	No
Society provides a demand for the service, can't realize the service itself	Partly, other health professionals provide similar treatment.
Skill level, prolonged higher education	Yes, 4 year degree courses, now mainly masters level.
Professional ethics	Yes
Able to cope in non-routine situations	No
Freedom of judgement	Partly, osteopaths are individual autonomous health practitioners.
Strong public voice	No, many people still unaware what osteopathy is.
Formation of an independent science	Partly, the science of osteopathy is not supported well by evidence.
High prestige	Partly, it is unclear what status others give to osteopathy.
High earnings	No
Crucial social function	No
Knowledge grounded in science	Partly, evidence is limited.
Elevating entry requirements	No, entry requirements are on the lower end of health degree courses.
Cross-functional skills	No

Table 3. An ideal type profession

The evidence from this study suggests that osteopaths in the UK positioned themselves to a status, equal to the established profession of medicine. This view was voiced during interviews from a senior and elite member of the medical establishment (L1 Q 5).

Osteopaths claimed to have a unique system of health care to offer people as an alternative, or complementary to, allopathic healthcare. UK osteopaths would have been very aware of the equal status in the USA between doctors of osteopathy and doctors of medicine.

From a comparison to the ideal type profession, as outlined in table 4, it is evident that osteopaths in the UK have become a profession, up to a point. The features which support a status of profession; state regulation, code of ethics, legal Standards, degree education, freedom of judgement and unique ideology, all suggest osteopathy is a modern health care profession similar to other allied health care professions such as; midwifery or physiotherapy. However, the features that osteopathy does not exhibit; high earning, crucial social function, elevating entry requirements, cross-functional skills etc., suggest that it falls short of being accepted a 'full status' health care profession. A full and frank exploration of other non-medical health care professions in the UK, arguably conclude the same.

Midwifery, nursing, physiotherapy, radiotherapy, occupational therapy and podiatry all fall short of the traditional ideal type 'profession'. They all function with varying degrees of subordination to medicine. The historically dominant health profession of medicine, is still dominant and has a higher status than any other health care profession, and continues to dominate the health care market (Larkin, 1983; Freidson, 1970).

This comparison with the ideal type might be misleading though. The usefulness of identifying an ideal type profession has been challenged (Empson, 2007) and the exploration and study of professionalism, has been suggested as more fruitful for sociological investigation (Freidson, 2001). One traditional identifying feature of a profession and also a fundamental aspect of professionalism, is the acquisition of knowledge produced by empirical research in the context of health care, or normative knowledge based on values within the context of non scientific professions, such as law (Freidson, 2001, pp.154-157). Lack of empirical knowledge unique to osteopathy, had been a barrier to progress historically.

Osteopathy was criticised during the 1935 House of Lords Select Committee, as having little or no scientific evidence to support its practice. A recent view from the mainstream scientific community suggests little has changed, claiming that albeit some developments have been achieved in osteopathic education, the success in legislative change was not established by significant scientific advances in osteopathic knowledge (Ernst, 2009). Arguably, there is empirical evidence that spinal manipulative therapy has a scientific basis, supported by the establishment of a number of international peer-reviewed scientific journals on the subject, published by Elsevier; *Manual Therapy* and *The International Journal of Osteopathic Medicine*. Also, recent national clinical guidelines published in the UK by the National Council for Health and Clinical Excellence (NICE), also supports the use of spinal manipulative therapy provided by osteopaths (NICE, 2009), although these guidelines have been challenged for their lack of scientific rigor (Ernst, 2009).

Osteopathy in the UK is still trying to increase its research credibility and establish an evidence base for its practice, evidenced by the creation of the National Council for Osteopathic Research (NCOR) in 2003; with a remit to: 'in order to explore and assure the place that osteopathy has to play in health care' (NCOR website).

It is proposed this lack of a significant scientific evidence base supporting osteopathic practice, appears to be limiting the development and professionalisation of osteopathy further. Osteopaths in the UK hold a wide range of beliefs about health and the mechanisms underlying osteopathic practise (Lucas, 2008). This relativism is very much at odds with mainstream health care, where the dominant ideology is biomedicine and a dominant scientific 'evidenced base' agenda exists. It would seem reasonable to suggest that UK osteopathy is required to develop its evidence base further and support its clinical practice and ideological principles with robust empirical scientific data. This may not be an insignificant challenge within the professions culture of relativism.

Further evidence of the professions relativism was suggested when the GOsC proposed a consultation in 2009 on, 'the identity and scope of practise of osteopathy' (GOsC consultation, 2009). This is an attempt to understand what osteopathy is, and what the limits to osteopathic practise might be. It is possible that for some, possibly many UK osteopaths, a clear definition is not desirable; the continued relativism is more acceptable, and allows for greater freedom in clinical practice and indeed freedom to create unique

and successful business models.

The question of a definition for osteopathy was raised by research question 4 in this study; 'does the data from investigating professionalisation of osteopathy in the United Kingdom, help to answer the broader question of; what is osteopathy?'. The data from this study provide some knowledge from which to define UK osteopathy more fully; its beliefs, aspirations, perceived identity, desired identity, social influences, political influences and professional status. However, the public or official version of osteopathy, may not be representative of individual osteopaths understanding of who they are (identity) and what they represent (definition). The evidence in UK osteopathy of the profession's relativism, requires further investigation to particularly explore, if the variety of beliefs held by UK osteopaths correspond to varying clinical practice. It may not be possible to provide a single or simple answer to, what is osteopathy?

It is yet to be seen, if the leadership of UK osteopathy aspire to place themselves in a more scientific and mainstream position. A challenge to the knowledge and evidence base on UK osteopathy has recently been taken up from another UK statutory body, the Committee of Advertising Practice (CAP). Guidelines from CAP on advertising has been highlighted with respect to health groups like osteopathy. The GOsC has responded in support of CAP, to ensure UK osteopaths are aware of their legal responsibilities with respect to unsubstantiated claims in providing health benefit to people. This is further warning, that UK osteopaths can neither neglect the scientific pursuit of knowledge, nor the legal responsibilities that prevail with clinical practice.

Professionalisation of UK osteopathy has followed a route where senior osteopathic policy makers optimised social and political circumstances using personal networks (which included strategic elites), to enable their goal of legislative change. The Osteopaths Act 1993, is evidence of a degree of professional status being bestowed upon UK osteopaths by society. Professionalisation of osteopathy, alongside chiropractic, has developed further than any other CAM group within the UK.

Further developments are required within UK osteopathy, particularly with regard to establishing a robust scientific knowledge base, if osteopaths are to be fully accepted as a modern health care profession. Establishing a discrete area of clinical practice where

medicine, or indeed any other health care profession, does not provide adequate service, may be necessary for osteopathy to occupy a mainstream health role in the future. This study provides an example of how a CAM group can develop its professional status. A greater challenge might be the maintenance, and enhancement of this professional status, which arguably requires more robust scientific evidence of clinical efficacy and cost effectiveness to support clinical practice.

Limitations of this study

This study was designed as a sociological interpretation of qualitative data on the professionalisation process of osteopathy in the UK, so by definition, there is a level of subjectivity within the study design and data analysis. A detailed explanation of the study design and a frank disclosure of the personal experiences of osteopathy by the author, combined with an explanation of the author's ontological and epistemological positions, provide a degree of transparency, and exposes the potential bias within data collection and analysis.

It is of note, that it was not possible to interview some key players within the events surrounding the Osteopaths Act 1993. It would have been helpful to interview Simon Fielding, who is identified as the architect of the Osteopaths Act 1993, and may have provided further information that was helpful to understand the processes in detail and to confirm or deny other sources of data, which would provide a greater degree of internal and external validity to the study. It could be argued that those individuals who did agree to interview, individuals who were identified as key players in the legislative process; may not necessarily represent an accurate view, or an objective view of the events, they presented their personal views on the questions asked of them, so the risk of subjectivity is recognised.

Future research

The identification and analysis of the data relating to the professionalisation process of osteopathy in the UK, has been conducted without exploring the views of other stakeholders or health care professionals. The extent to which stakeholders; politicians, health policy makers, medical elites, non-medical elites and the general public view the

achievement(s) of osteopathy in the UK, its professional status and osteopaths' level of professionalism, is still widely unknown. To understand more fully the role of osteopathy in the UK's health care provision, it would be necessary to explore the identity and status given to osteopathy by other health care professional groups, politicians and policy makers. Exploring the value and benefits of osteopathic treatment to patients would also be imperative, to gain insight of the 'real' value of osteopathy to society.

The extent of success in the professionalisation of osteopathy, as viewed by the osteopathic community itself, is also unknown. Research to explore the views of UK osteopaths on how far professionalisation has progressed, and to what extent the Osteopaths Act 1993 achieved professionalisation goals, would be helpful.

The suggested barriers to further professionalisation that this study highlights, justifiably requires exploration of how widespread the prevailing culture of relativism is within the osteopathic community. Further, study to explore the views of leadership groups within UK osteopathy, specifically on the issues surrounding relativism and the importance of empirical scientific research would be helpful; and may provide insight to the future likely activities and professional status of UK osteopathy.

Conclusions

Historically belonging to a profession has brought privilege, particularly high financial reward and social status. The process (professionalisation) of developing an occupational group towards this goal occurred within health care primarily during the early part of the Nineteenth Century. Health care groups aspired to protect their title and secure identity, as well as developing a degree of autonomy within the division of labour in health from the dominant group – medicine. All health care groups still operate varyingly subordinate to medicine, with dentistry gaining most autonomy. The professional identity or status of CAM groups is not so clear.

This case study identified that one of these CAM groups, osteopathy, existed on the fringe of mainstream health care until recently. A significant stage in a professionalisation process, the establishment of a statutory register, occurred in osteopathy with the establishment of the Osteopaths Act 1993. This was achieved by a small number of politically active osteopaths using their personal networks, at a time when the political climate of the Government was favourable and social changes in health care had resulted in osteopathy being widely used by a broad cross-section of society, as well as strategic elites. These social and political changes, resulted in muted opposition from the historically resistant medical and scientific community; with HRH Prince of Wales leading the 'charge' against these powerful groups. Osteopathy in the UK has gained a degree of professional status with statutory legislation and other educational developments. However, there appears to be a limit to the level of professional status osteopathy is granted. A sparse scientific evidence base to osteopathic theory and practice is still a concern, and although establishing a General Osteopathic Council confers a degree of reward for osteopaths, the purpose of a statutory register is to protect the general public to ensure safe and competent clinical care is delivered.

Recent legislative changes in health regulation within the the UK, as a result of the Shipman Enquiry (DH final report 2005) and the report 'Good Doctors, Safer Patients' in 2006 (Department of Health, 2006a); has removed the autonomy of health professions both medical and non-medical to a significant degree. Emphasis is placed on independent, 'lay' led regulation, providing independent oversight of education and 'fitness to practice'

proceedings. These changes remove some of the privileges of a profession, a changing attitude to professions by society. No longer are professions permitted to regulate, control and police themselves; they no longer have the autonomy that traditionally was their defining feature and separated them from other occupations (Freidson, 1970, p.82).

Although the power, status and autonomy of professions might be declining; the appeal and importance of 'professionalism' to society (Freidson, 2001; Hanlon, 1998), and as suggested by Evetts (2003, p.407) ' how professionalism as normative value system and ideology is now being used in modern organisations, and other institutions and places of work, as a mechanism to facilitate and promote occupational change'; suggests that a professional is working in a very different landscape to their historical roots.

Glossary of terms

AOA	American Osteopathic Association
BMA	British Medical Association
BSO	British School of Osteopathy
BOA	British Osteopathic Association
BOS	British Osteopathic Society
BCOM	British College of Osteopathic Medicine
CAM	Complementary and Alternative Medicine
CNAA	Council National Academic Awards
CNHC	Complementary and Natural Health Council
CPSM	Council for Professions Supplementary to Medicine
CSP	Chartered Society of Physiotherapists
DH	Department of Health
DO	Diploma of osteopathy (United Kingdom), Doctor of osteopathy (USA)
EEC	European Economic Community
GCC	General Chiropractic Council
GCRO	General Council and Register of Osteopaths
GMC	General Medical Council
GOC	General Optical Council
GOsC	General Osteopathic Council
HPC	Health Professions Council
HRH	His/Her Royal Highness
KF	Kings Edwards Hospital Fund
MD	Doctor of medicine
MP	Member of Parliament
NCOR	National Council for Osteopathic Research
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
NMC	Nursing and Midwifery Council
OAGB	Osteopathic Association of Great Britain
PFIH	Princes Foundation for Integrated Health
RCP	Royal College of Physicians

RCS	Royal College of Surgeons
RSM	Royal Society of Medicine
RQ	Recognised Qualification
SC	Select Committee
SSR	Statutory Self Regulation
UK	United Kingdom
USA	United States of America

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APPENDIX A

Participant Information Sheet

You have been identified as a highly influential person involved in the professionalisation process of osteopathy in the United Kingdom. You are invited to take part in a research study exploring the processes that have taken place in professionalisation and particularly the creation of the Osteopaths Act 1993.

The research is being conducted by Tim McClune as a PhD thesis at the University of Brighton.

The study has been reviewed and approved by the University of Brighton Research Ethics Committee.

If you are willing to take part in this study, you will be asked to have an interview. This interview will be primarily non-structured, allowing you to discuss and explain your memories, ideas and participation in the processes around osteopathy and its professionalisation. For accuracy and academic robustness you will be asked if you are willing to have the interview recorded, this will allow accurate transcribing to text.

You will probably have received this information by post; I will contact you within the next few weeks and ask if you are willing to take part in this doctoral study. If you are willing, I will arrange an interview date and time, at a location that is most convenient to you, and discuss any questions or concerns you may have. I have enclosed a consent form for you to sign if you are willing to take part in this study.

Participation in this study is entirely voluntary. You are not obliged to participate, and if you do participate you can withdraw at any time without prejudice.

The recording of the interview and transcribed data will be stored in a secure location. The storage will be in accordance with the University of Brighton's regulations for research data storage.

If you are willing to participate, you will be asked about anonymity, and how you wish to be identified within the study. You have the right to remain anonymous if you wish.

To contact me: tim@spineresearch.org.uk

Work phone 01484 424329

If at any point you have a concern of complaint about the conduct of this research study contact Professor Ann Moore, Director of the Clinical Research Centre for Health Professions, University of Brighton, Aldro Building, 49 Darley Road, Eastbourne, BN20 7UR. Tel: 01273 643647. Email: a.p.moore@brighton.ac.uk

Participant Consent Form

- I agree to take part in this research study, which will explore the professionalisation processes of osteopathy in the United Kingdom
- The researcher has explained to my satisfaction the purpose of the study
- I agree to be interviewed in regard to the topic of this study
- I understand that I am free to withdraw from the study at any time

(Please circle)

I agree to a recording of my interview

YES I AGREE

I do not agree to a recording of my interview

NO I DON'T AGREE

I agree to being named in the study

YES I AGREE

I do not agree to being named

NO I DON'T AGREE

Name (please print)

.....

Signed

.....

Date

.....