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Alternative futures: Fields, boundaries, and divergent professionalisation strategies within the Chiropractic profession

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ABSTRACT

Sociological studies of the complementary and alternative medicine (CAM) occupations have documented the professionalisation strategies these groups use to establish boundaries between themselves and their competitors, including seeking educational accreditation and statutory regulation/licensure. Chiropractic has been particularly successful at professionalising and in Australia and the UK it is taught within public universities. Recent events have threatened chiropractic's university foothold, however, showing that professionalisation needs to be understood as an ongoing process of negotiation. Based on interviews with chiropractors in Australia and the UK, this paper examines the professionalisation strategies deployed by chiropractors within and outside of the university. Highly divergent strategies are identified across different sectors of the profession, relating to defining the chiropractic paradigm, directing education and constructing professional identity. In each domain, chiropractic academics tended to prioritise building the evidence base and becoming more aligned with medicine and other allied health professions. Although some practitioners supported this agenda, others strove to preserve chiropractic's vitalistic philosophy and professional distinction. Following Bourdieu, these intra-professional struggles are interpreted as occurring within a field in which chiropractors compete for different forms of capital, pulled by two opposing poles. The differing orientations and strategies pursued at the two poles of the field point to a number of possible futures for this CAM profession, including a potential split within the profession itself.

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1. Introduction

Professionalisation, the process by which an occupational group increases its status and works to affect the reproduction of itself as a distinct profession, typically by monopolising certain services and controlling access to its specialist knowledge (Turner, 1995), has long been of interest to sociologists. Medicine has been described as the quintessential profession (Martin et al., 2009; Turner, 1995), and other occupational groups, including the various complementary and alternative medicine (CAM) occupations, have struggled to gain a foothold in the health space it dominates. The strength of the professional boundaries between medicine and its competitors has been repeatedly demonstrated (e.g. Dew, 2000; Norris, 2001; Saks, 1996, 2003; Willis, 1983).

Chiropractic is one CAM occupation that has been quite successful in attaining the formal criteria of a profession. Despite this, chiropractic remains largely marginalised from public health systems and continues to strive to improve its position. Importantly, there is significant debate within the chiropractic profession over how to best shape its future. Using chiropractic as a case study, this paper aims to add to our understanding of professionalisation by examining not the boundaries between professions, but boundaries *within* a single professional group. Specifically, the paper asks what professionalisation strategies are being pursued within the chiropractic profession? What boundaries are constructed in the process? And, how do these strategies position the chiropractic profession for the future? By drawing attention to divisions within a profession, and by studying the ongoing professionalisation processes that occur once formal professional status has been achieved, the paper seeks to build a more accurate and refined picture of professionalisation and the divergent strategies it can

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entail. It does so with particular reference to Bourdieu's theoretical framework, arguing that these conceptual tools add nuance and capture dynamics that are downplayed in professionalisation studies.

The paper draws from a study carried out in Australia and the United Kingdom that explored the professional status of chiropractic and other CAM groups in relation to their position and the form they take within these countries' higher education systems. Most empirical work on chiropractic has focused on North America, so this study expands the knowledge base to other geographic contexts as well as shifting the theoretical frame. The paper begins with a short overview of chiropractic's history and status in Australia and the UK and discusses literature on professionalisation in CAM. Next, drawing on the work of Bourdieu, the importance of expanding our understanding of professionalisation is discussed. The remainder of the paper focuses on the empirical study, which illustrates the role that professionalisation strategies can play in driving intra-professional divisions.

1.1. History and status of the chiropractic profession

Chiropractic was founded in Iowa in 1895 by Daniel David Palmer, a magnetic healer who claimed to discover the therapy after performing a neck manipulation on a janitor who was subsequently cured of deafness (Kaptchuk and Eisenberg, 1998). Palmer (1914:48) proposed that 'the direct cause of disease (abnormal functionating [sic] and morbid tissue) is subluxated joints; about 95 per cent. of which are slightly displaced vertebrae … '. It is these 'subluxations' that chiropractors have traditionally sought to remove through 'adjustments' to the spine and other joints. Palmer conceived subluxations as blockages to the body's own ability to maintain health and the chiropractic adjustment as restoring the flow of this 'innate intelligence'. These key chiropractic concepts are therefore rooted in a vitalistic philosophy and were conceived as alternative to the biomedical model (Villanueva-Russell, 2005, 2011).

Chiropractic gradually spread to countries outside the United States from the turn of the twentieth century, including to the UK and Australia where, as in the USA, it has been relatively successful in establishing itself as a profession, eventually achieving statutory registration and protection of title (the equivalents of licensure in the USA), access to private health funds and accredited training. In addition, and in contrast to the USA (Villanueva-Russell, 2011), in both the UK and Australia chiropractic degrees are offered by major public, multi-faculty universities. The establishment of university degree programs in the early 1990s to the early 2000s, gradually replacing private college diplomas, was seen as a major achievement by many in the profession (O'Neill, 1994) and is also a marker of professional status from a sociological perspective (Turner, 1995). However, more recently, chiropractic's location within universities has come under public attack by sceptics in these countries (mostly biomedical professionals) who have argued that CAM disciplines are not 'evidence-based' and have no place in public academic institutions (Brosnan, 2015). Chiropractic was particularly targeted in the campaigns, and, in Australia, following lobbying by the group Friends of Science in Medicine, a number of universities reviewed their chiropractic departments, in one case shutting down aspects of clinical teaching; in another, threatening the department with transfer/closure (Brosnan, 2015).

These recent struggles over chiropractic's legitimacy demonstrate that once an occupation has attained the hallmarks of a profession, these can be lost again. Professionalisation does not cease at the point of statutory recognition or accreditation, but is an ongoing process of negotiation (Villanueva-Russell, 2005:550), in constant tension with the threat of deprofessionalisation (Toren, 1975). Being at a 'crossroads' is a motif used repeatedly by chiropractors to describe their professional situation (Reggars, 2011), the major challenge being how to reconcile the profession's philosophical tenets with the positivist science of evidence-based medicine (Villanueva-Russell, 2005). The next sections consider how to comprehend these dynamics through a sociological lens.

1.2. Sociology of chiropractic and the CAM professions

Prior work on the CAM professions has emphasised their relationship to the medical profession and how the latter's dominance has affected CAM's status in the healthcare system (Almeida and Gabe, 2016; Dew, 2000; Saks, 1996; Willis, 1983). While the allied health professions (nursing, physiotherapy, occupational therapy and so on) have traditionally worked under medicine's control, with increased autonomy in recent years, CAM has often been defined by its marginalisation from mainstream healthcare. Various studies have explored CAM groups' struggles to achieve state recognition, accreditation of training, and to legitimate their knowledge bases (Cant and Sharma, 1995; Dew, 2000; Givati and Hatton, 2015; Kelner et al., 2006; Saks, 2003). For instance, Kelner et al. (2006) identify the specific professionalisation strategies used by Ontarian chiropractors to gain acceptance, namely, incorporating more science into their education, standardising practice and increasing scientific research.

Gale (2014:808) has recently observed of the sociology of CAM professions that most research follows a neo-Weberian approach, which emphasises how a combination of group self-interest and market-based rivalries prompts the establishment and preservation of occupational boundaries. Working within this perspective, Saks (2003) argues that professions' power comes essentially from state regulation and credentialism, ensuring social closure. The neo-Weberian framework therefore draws attention to the structural factors underlying professional groups' differentiation from each other. Perhaps one reason it has dominated studies of CAM professions is because it assumes hierarchical access to power and resources between professions (Liljegren, 2012), such hierarchies being central in medicine's relationship to CAM in the health arena.

The reliance on neo-Weberianism has, however, obscured some important aspects of professionalisation (Gale, 2014; Villanueva-Russell, 2005). Firstly, the emphasis on professions' legal protections leaves unexamined the professionalisation processes that continue beyond formal occupational closure (Villanueva-Russell, 2005). Secondly, by emphasising the structural conditions underpinning professional boundaries, less attention has been paid to boundaries *within* professions. Villanueva-Russell (2005, 2011) asserts that this theory is of limited help in explaining the case of chiropractic, which is a profession riven with internal divides.

Villanueva-Russell (2005, 2011) has used documentary methods to explore divisions within the chiropractic profession in the USA. Almost from the beginning there was a divide between the 'mixers' – who combine chiropractic adjustments with other techniques – and the 'straights', who rely only on manual adjustment and are more likely to view chiropractic as an alternative to medicine (Kaptchuk and Eisenberg, 1998; Villanueva-Russell, 2005). A more contemporary division is between those who adhere to vitalistic philosophies and those pushing to become science-based, musculoskeletal specialists (Villanueva-Russell, 2011). While the musculoskeletal group advocate narrowing scope to neck/back pain management, vitalistic chiropractors are more likely to argue for an expansion of scope to include emotional and psychological well-being (Villanueva-Russell, 2011:1830). Both strategies might be conceptualised as an attempt to diversify and thereby expand the profession's role (Nancarrow and Borthwick, 2005): one by incorporating new approaches for a specific set of conditions; the other

by applying limited approaches to a wider range of conditions.

Villanueva-Russell (2011:1829) shows that chiropractic discourses involve 'rancorous name-calling in an effort to distance one segment from another and to denigrate colleagues as an undesirable "other"'. Various characterisations are between 'subluxationists' and those who follow 'science' (Reggars, 2011) and between 'fundamentalists' and 'progressive chiropractors' (Villanueva-Russell, 2011:1830). The implications of taking different paths are also debated. Some have suggested that subluxation is the distinguishing concept that binds chiropractic as a profession (Wardwell, 1996). However, chiropractors writing in academic journals typically see the adherence to vitalism as hindering the profession (e.g. Reggars, 2011; Walker, 2016). Villanueva-Russell (2011:1835) argues that the views of 'everyday' chiropractors are being 'systematically silenced' by academics with greater opportunities to shape professional discourses.

This paper builds on Villanueva-Russell's work, using interviews rather than document-analysis to identify and understand the professionalisation strategies being pursued by chiropractors in Australia and the UK. Unlike Kelner et al.'s (2006) interviews with chiropractic 'leaders', whose views tallied with those of the 'academic' chiropractors described by Villanueva-Russell (2011), my study captured a broader range of perspectives across the profession. Additionally, this paper attempts to offer an alternative to the neo-Weberian approach to understanding professionalisation, drawing on Bourdieu's framework to make sense of chiropractic divisions.

2. Theorising intra-professional boundaries and fields

In his treatise on reflexive sociology (Bourdieu and Wacquant, 1992), Bourdieu singles out the sociology of professions for special criticism. Work on 'professions', he argues, is too closely based on the common-sense assumption that professions are special groups with particular, shared, characteristics:

> The category of profession refers to realities that are, in a sense, 'too real' to be true, since it grasps at once a mental category and a social category, socially produced only by superseding or obliterating all kinds of economic, social, and ethnic differences and contradictions which make the 'profession' of 'lawyer' for instance, a space of competition and struggle (Bourdieu and Wacquant, 1992:243).

According to Bourdieu, sociologists too readily accept formal, legal definitions of professional membership, and therefore overlook the diversity and power dynamics within professional groups. More relevant are the various *fields* in which professionals operate (Bourdieu and Wacquant, 1992:242). Fields are one of Bourdieu's central concepts, comprising a 'structured space of social forces and struggles', in which there is always a competition for resources or capital: economic, symbolic, social, cultural and so on (Bourdieu and Wacquant, 1992:243). Each field involves a 'game' to define the stakes of the struggle, to determine what counts as capital, and to gain more capital on this basis. Agents invest in the game because of a shared and taken-for-granted belief in the stakes; this is the *doxa* of the field (Bourdieu and Wacquant, 1992:98). Agents' positions and strategies in the game derive from their *habitus* (enduring perceptions, dispositions, tastes and aspirations, developed through familial and educational experiences) and agents may challenge the *doxa* when their habitus does not afford access to capital valued within the field (Bourdieu, 1988; Bourdieu and Wacquant, 1992:101). Fields also vary in their autonomy; in more heteronomous fields, the stakes of the game will be influenced by other, external fields to a greater extent. Within a field there may be different degrees of autonomy/heteronomy at opposing poles (Bourdieu, 1988).

Bourdieu somewhat overstated his critique of the sociology of professions. Others had already noted the different 'segments' within occupations, involving different beliefs and identities (Bucher and Strauss, 1961; Hughes, 1971). Freidson (1994) also highlighted the restratification that occurs within professions when autonomy is threatened, with groups of 'elites' emerging to steer the work of the everyday practitioners. Such internal divisions have been studied in the professions of nursing (Melia, 1987), medicine (Martin et al., 2009), academia (Musselin, 2013) and occasionally within CAM occupations (Degele, 2005; Villanueva-Russell, 2011). Gieryn's (1983) concept of boundary-work, developed to explain how scientists go about differentiating science from non-science in order to promote a public image of science, also sheds light on intra-professional struggles. Gieryn states that 'when the goal is monopolization of professional authority and resources, boundary-work excludes rivals from within by defining them as outsiders with labels such as "pseudo," "deviant," or "amateur"' (1983:792). Boundary-work can be enacted through formal or informal means (e.g. at the policy level versus via daily interactions) (Mizrachi and Shuval, 2005).

Boundary-work theory has had significant uptake but, with a few exceptions (McDonald, 2014; Schinkel and Noordegraaf, 2011), Bourdieu's suggestion around conceptualising professions as fields seems to have scarcely been heeded. The potential of field theory to understand intra-professional divisions remains largely unexplored. Without accepting Bourdieu's notion that sociologists should forget the very idea of 'professions', in this paper I attempt to demonstrate how conceptualising chiropractic as a field helps to explain the internal dynamics and contrasting strategies pursued within this group, and to understand the implications of the field's structure for the profession's future.

3. Methods

The data presented here come from a three-year study (2014–2016) of CAM professions within Australian and British universities, including osteopathy and Chinese medicine alongside chiropractic. Australia was the primary focus of the study with the UK included as a comparator case to gauge the effects of sceptic campaigns that had begun several years earlier there. While epistemic cultures in osteopathy and Chinese medicine are discussed elsewhere (Brosnan, 2016), this paper focuses on chiropractic as an example of a profession characterised by deep internal epistemological struggles. The paper draws primarily on 23 in-depth interviews with key stakeholders in chiropractic education and the profession.

Chiropractic degrees are offered by four Australian and three British universities. Because of the relatively small number of institutions, potential differences between them, and slow recruitment at some sites, I decided to approach all seven chiropractic departments. Heads of departments were contacted, with six agreeing to allow recruitment of staff. Academic staff members in these departments were then emailed and invited to participate. All who agreed to participate were interviewed, with between one and six individuals taking part in each department. This included thirteen academic chiropractors and three non-chiropractor academics (with backgrounds in basic science). These latter three interviewees had worked in academic chiropractic for many years, published in chiropractic journals, and included key players in the chiropractic field involved in national or international chiropractic associations or research initiatives. All are referred to in this paper as Chiropractic Academics.

Another seven chiropractors working outside of universities,

with roles in regulation, professional associations or education advisory boards - but primarily working as practitioners - were interviewed (here referred to simply as Chiropractors). These interviewees were selected and recruited either purposively through their professional role, via snowball sampling, or, in several cases, when they contacted me after hearing about the research. The two participant groups fit loosely into what Waring (2014) (following Freidson) delineates as the 'knowledge elites' (e.g. researchers) and 'political elites' (with formal roles in associations) of the profession, although several fitted both categories. A limitation of the study then is its focus on elites, rather than 'everyday' practitioners. However, as will be seen, this still yielded a wide range of views on each end of the chiropractic spectrum.

I also conducted observation in two chiropractic degree programs, one in Australia and one in the UK (totalling 35 h). This involved attending lectures, practical classes and the campus-based clinics where students treat patients. The combination of observation plus interviews enabled a rich understanding of practice and context to emerge, helped to strengthen rapport in both settings and exposed me to a wider range of perspectives than one method alone (Atkinson and Coffey, 2003). In this paper, however, I focus on the discursive constructions of legitimate chiropractic expressed in the interviews. I treat these utterances as representations of interviewees' dispositions, aspirations and judgements, and analyse them through a Bourdieusian frame to map out the contours of the field/s within which participants are invested (Bourdieu, 1999). Using the constant comparative method, recurring themes were identified across the interviews. Particular attention was paid to the kinds of distinctions participants made and the forms of capital they possessed and promoted (Bourdieu and Wacquant, 1992). Member-checking helped ensure my interpretations tallied with participants' experiences. Because data collection and analysis took place over a two-year period, early interpretations were discussed with later participants, and ongoing contact was maintained with key informants, including via the observation. A range of key distinctions and strategies emerged across the interviews and are reported under three key categories in the findings section.

Interviews lasted 1 h on average and were recorded and transcribed with NVivo11 used to help organise the analysis. Ethics approval was received from the Human Research Ethics Committee at the University of Newcastle (approval number H-2014-0023) and all participants gave written informed consent. This included the understanding that participants and institutions would be de-identified. All chiropractic university education settings are described as 'departments', even though some refer to themselves as colleges.

4. Findings

The study exposed similar divisions among Australian and British chiropractors as Villanueva-Russell describes in the USA, namely a tension between those advocating a mainstream musculoskeletal focus and those attached to more traditional approaches. What united the vast majority of participants was a sense that the chiropractic profession was in crisis and that some sort of action was needed to protect its future. In Bourdieusian terms this might be understood as the investment in the game - the *illusio* - that underpins the field. Different professionalisation strategies and forms of capital were pursued according to the different 'principles of legitimation' at two poles of the field (Bourdieu, 1988:48), depicted in Fig. 1 (following Swartz's (1997:139) representation of Bourdieusian fields). Three key but overlapping areas of struggle are discussed here, relating to: defining the chiropractic paradigm; directing chiropractic education; and constructing professional identity.

4.1. Defining the profession's paradigm

The central competition of the field was over how to define legitimate chiropractic. The professionalisation strategies pursued by agents in the field were inseparable from this overarching struggle. Most of the chiropractic academics believed the profession's future depended absolutely on its becoming 'evidence-based'. For instance:

> I think if chiropractic is to remain viable in the university system it has to be fully evidence-based. Anything else just won't be tolerated. The new term I heard rolled out by one of the American college presidents a few months ago — 'neo-vitalism' - that's the new one now. Basically, untestable hypotheses are not going to — they're not going to make it. (Chiropractic Academic 8, Australia)

The academics often used boundary-work strategies to dissociate themselves from the vitalistic sectors of the field, which they constructed as a deviant minority:

> It's a shame [critics] don't see that we are teaching an evidence-based program and what have you. They tend to look at the fringe chiropractors in practice who don't necessarily treat in a way that's in line with medicine and assume that's what we do. (Chiropractic Academic 1, Australia)

For some, this strategic boundary-work included a rejection of the chiropractic subluxation, framed as an anachronistic hangover from the profession's past:

> I just think that the profession has to modernise and the way things have changed in healthcare, particularly around things like evidence-based medicine, patient-focused care, that kind of stuff, and that's the standards that all healthcare professionals are judged against, not just us. It's everybody. So why shouldn't we be adapting those principles, as opposed to telling people or relaying the message that people did 150 years ago when healthcare was just emerging, wasn't it? That misalignments of the spine caused all these diseases. (Chiropractic Academic 13, UK)

The emphasis in these comments on 'testable hypotheses', treating 'in line with medicine' and evidence-based medicine illustrates the academics' orientation to wider fields beyond chiropractic, i.e., to science and medicine. This is not surprising given that these participants' primary professional milieu was now the university, which attracts and rewards those with scientific dispositions. Other agents in the field also held similar dispositions, however. For example, a member of one professional association explained:

> [Our association] won't accept as members people who have got vitalistic views. So when somebody applies for membership, we have a look at their website and any advertising material that we can see, basically from their website or their Facebook page we look at, and if there's vitalistic kind of stuff or old-time subluxation stuff on their social media, we write to them and [ask them to change it]. … We don't want to service that membership. (Chiropractor 3, Australia)

This shows that the struggle is not simply between academics and practitioners but cuts across the profession. Indeed, there are not one but two separate professional chiropractic associations in

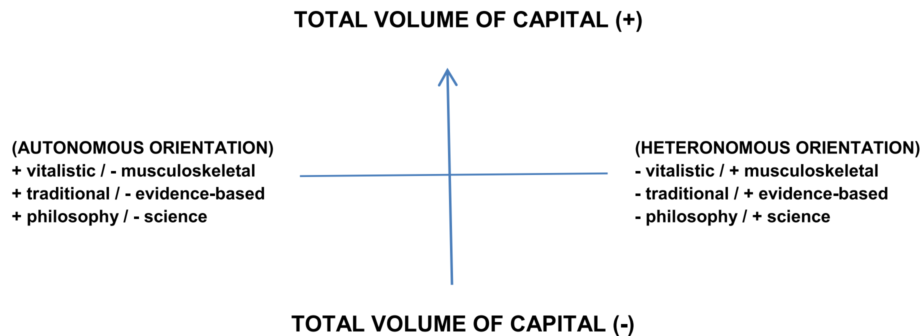

Fig. 1. The principles of legitimation at the two poles of the chiropractic field.

Australia, and four in the UK, each taking a differing stance in the vitalistic-musculoskeletal debate.

There was also some subtle variation among university departments, more notable in the UK where chiropractic remains slightly less integrated into mainstream university education (one department is in a private university; another institution's degrees are validated by rather than incorporated into a university). Although the musculoskeletal, evidence-based discourse was dominant within chiropractic departments there, and a UK chiropractic academic asserted that, nationally, ‘the educators are quite united’ on this front (as opposed to practitioners), one UK institution remained somewhat more open to retaining vitalism alongside evidence-based perspectives. There were also practitioner-chiropractors who took a middle-ground, arguing that both styles of practice have value. Chiropractor 6 (Australia), for instance, characterised some colleagues as ‘too vitalistic’, and explained that he gauges when to introduce a vitalistic approach depending on the case:

> There's nothing wrong with the duopoly of saying I have a vitalistic approach, but when you walk in to see me I want to see if the case warrants some X-rays and I want to look at certain tag indicators on base measurements that are done … And so we have a safe, structured approach to care with the vitalistic approach, saying, ‘You know, this can be a lot more if you want it to be. Let me know what you want and we'll go from there. Philosophically I'd like to do these things with you, where are we going to meet?’.

Located towards the other pole of the field were those who believed chiropractic's future lay most crucially in preserving its unique philosophy, a perspective I heard only from those outside universities. The same kinds of boundary-work were enacted within this group to demarcate and exclude rivals within the profession (Gieryn, 1983):

> My feeling is that chiropractic is chiropractic and it is vitalistic and you can't have it any other way. So really, anyone who's doing anything different is not really doing chiropractic. (Chiropractor 7, Australia)

For this group, the most legitimate forms of capital were not stocks of research and evidence, but hands-on skills, satisfied patients, and an understanding of chiropractic's special principles. Professionalisation strategies involved promoting and practising according to traditional vitalistic philosophy. Chiropractor 4 (Australia) explained:

> We're doing a lot more than moving of bones. We think that by doing what we do, I enabled you to be better at being all of who you really are. Because at less than full function, you're not all of Caragh. So how does that manifest? That manifests by bringing someone in who's actually not symptomatic and working on them and finding problems that aren't symptomatic, but are nonetheless present, which I find has restricted movement or altered position, and I adjust them and I watch what happens to you, and you come back and say, ‘You know, I've never slept better than this’. … If it sounds like chiropractors overexert their philosophical position, it's because they're bound up with these principles that they would love the world to really appreciate.

Treating in the absence of symptoms is something that many chiropractic academics specifically criticised when describing reforms needed within the profession, often with the implication that it was a money-making strategy. For Chiropractor 4 and others, however, it was an essential part of enabling chiropractic to improve people's lives — to go from pain-free to a state of ‘wellness’.

Unlike the academics who either rejected or gave ambiguous answers regarding the existence of subluxations, Chiropractor 4 talked in great detail about their various features. At one point during the interview he used my wrist to demonstrate the difference between manipulation and the chiropractic adjustment. He and others in this sector of the field spoke passionately about the need to recognise and protect chiropractic philosophy and expertise:

> I need someone to understand the subtleties of what we do with our hands in terms of identifying the skill we use to identify what we do and correct it. Because none of that's scientific, that's art! (Chiropractor 4, Australia)

Strategies to ensure the preservation of chiropractic philosophy described by these interviewees included giving seminars at chiropractic conferences and providing informal mentoring to other chiropractors. One participant held regular Skype tutorials with a group of students based on a university campus, so they would learn the philosophy they were not being taught in their official program (illustrating the way that formal and informal kinds of boundary-work can sometimes work in opposition (Mizrachi and Shuval, 2005)). Knowledge of chiropractic philosophy can therefore be translated into cultural and economic capital within the chiropractic field. The alternative set of values and strategies - prioritising science and evidence - draws capital from external (academic and medical) fields, yet is competing to become doxic within the chiropractic field itself. One key arena where this struggle occurs is in chiropractic education.

4.2. Directing professional education

The shift from private colleges to public universities brought chiropractic into contact with other academic fields and has provided access to some of the forms of scientific capital mentioned above. Over time, the chiropractic academics reported, there has been increased emphasis within chiropractic departments on teaching evidence-based material and developing research programs. While there has often been pressure from the universities to increase these activities – particularly following the sceptics' campaigns – most academics felt that such steps were positive and would help to shore up the profession's status. Staying within the university system was seen as of paramount importance:

> I've never agreed with Friends of Science in Medicine trying to get these courses out of universities because it just doesn't seem to make any sense. It will just create more and more fringe practice than being in the university system where it's more evidence-based and I think the best way to try and fix it is just turn out as many new chiropractors as possible, who yeah, have that evidence-based training so that they can see when things are not quite right, that they're being told out in practice. (Chiropractic Academic 1, Australia)

Chiropractic Academic 1's comment indicates that part of the strategy of training students to practice in an evidence-based way is to shift the field more generally in this direction, by producing new chiropractors with a shared habitus forged in the academic sector of the field. The implication is that graduates will meet other, less legitimate approaches when they go out into practice – those held by older chiropractors who were not taught to use scientific evidence - which they need to be trained to resist. This suggests that the academics had developed a habitus that oriented them outwards from the professional field itself. In another example, when I asked an academic whether he felt the department was accountable to the profession, he replied:

> Less so; becoming more confident. We were, yes, absolutely, and we still - you know, the profession obviously is an important stakeholder. But sometimes they get involved with stuff they shouldn't get involved with. I think over the years … we've become more confident as an academic institution. (Chiropractic Academic 14, UK)

Significantly, here the profession is deemed to be just one stakeholder in chiropractic education - one that sometimes interferes in areas best left to academic expertise. It appears that, over time, the academic sector has become increasingly heteronomous – outward-facing, and distinct from the professional core. This suggests a possible process of restratification with knowledge elites attempting to redefine the core knowledge of the profession and thereby protect its status (Freidson, 1994; Waring, 2014).

Course content had been revised over the years, with vitalistic concepts such as subluxation generally now included as 'historical constructs' rather than explanatory principles to be used in practice. Boundaries between 'traditional' and 'modern' chiropractic were sometimes drawn explicitly in the classroom. For example, once when a student mentioned the word 'intent' in a practical class, the supervising academic raised his arms and eyes to the ceiling in a pseudo-religious pose and groaned, 'Oh, the *intent*'. He explained that he was suspicious of this word which, during his own education, had had metaphysical connotations.

The requirement for evidence also meant that course content was becoming less chiropractic-specific:

> I think we feel very confident about providing education that allows our students to pretty much do the same thing as physiotherapists would do who were specialising out there in the independent sector for musculoskeletal pain. … Chiropractic care contains a whole bunch of different things that you have the skill and the competencies to be able to do safely and effectively, put together as a package individualised to a patient. People say, 'Well yes, but that's no different from physiotherapy or osteopathy'. Well no, it isn't, and you know why? Because that's where the evidence is, and if we're all following the same evidence you would think it would probably look similar. (Chiropractic Academic 15, UK)

Participants inside and outside the university were open to drawing on research and evidence from other manual therapy professions like physiotherapy, particularly given the current scarcity of good quality research evidence specific to chiropractic. However, this also potentially increased the risk of deprofessionalisation, as Chiropractic Academic 9 (Australia) noted:

> I think what some chiropractors are concerned about is if they lose that extremely distinct difference, that in the end the other professions will usurp it all and we'll be left as well. Which is why - which then leads to the other issue that's very important is to get the research out there. Because if all the research out there on manipulation is coming out of physiotherapy, then physiotherapy will eventually take it over and the chiropractor will just be fringe stuff.

For this participant, the solution to the dilemma lies in pursuing academic forms of capital, i.e., increasing chiropractic's research base. For chiropractors situated closer to the vitalistic, more autonomous pole of the field, however, the solution was to place less emphasis on research and more on ensuring chiropractic's distinct skills and philosophy continued to be taught. Chiropractor 4 (Australia) lamented that, in the university system:

> [Chiropractic academics] are so research-paranoid that they have forgotten that their principal task is to actually produce a clinician, not a researcher. … [Chiropractic] philosophy is not taught within the program now … So people now wonder why they've got an identity crisis when they come out as to, not only, *who am I*? But, *what am I*?

The tension over the direction that chiropractic education should take is, at the time of writing, culminating in at least two projects in Australia aimed at establishing new chiropractic programs outside of universities. This is a significant development: entry to the university was hard-won and seen as a major achievement for the profession, so a desire among some to return to independent, private-college education points to the deepening chasm between the two poles of the field. As a backlash against the university programs, it suggests the increasing dominance and perceived threat of the musculoskeletal approaches they favour. The rise of these counter-initiatives in Australia also perhaps reflects the slightly greater educational homogeneity there as opposed to the UK, noted above.

The emergence of these new degree programs also shows that restratification processes can be contested: in this case, efforts of the knowledge elites are being resisted by certain political elites, themselves attempting to define the profession's knowledge base. Chiropractor 7, involved in one of these projects (with experience as a leader in the profession, but not as an educator), explained his wish to redress an increasing imbalance he perceived in what was

being taught within universities, and to produce philosophically-trained chiropractors for the future:

> When we have these colleges that say that a classic chiropractic philosophy is worthless and useless, I have a personal issue with that, because I've felt it work and I've experienced it work. … The drive behind this [new] college is because I feel as though that way of chiropractic thinking is dying. … So it's not really about having a college, it's about the effect of having a college. So it's having something which can institutionalise those values and those principles about philosophy.

This is clearly a strategy oriented towards autonomy and the reproduction of practitioners recognised as legitimate within the chiropractic professional field, and not necessarily in external fields of healthcare and academia. Chiropractor 7 explained that the governance model for the new college would itself be vitalistic, that is, driven internally rather than shaped by outside influences. It is also apparent though that the values espoused at the opposite pole of the field - the more heteronomous side, aligned with the universities and where the majority of academics are clustered - had permeated the field as a whole. The same participant went on to add that, in the new college:

> We can still be evidence-based because there's enough evidence to support that way of practice. We can still do our own research which backs up that way of thinking.

This suggests that the requirement for research and evidence has become generally accepted — doxic - in the chiropractic field (although how such things are defined, and how much is needed, remains contested) and that new educational initiatives are unlikely to simply return to pre-university era formats.
Chiropractor 7 outlined two possible futures for the profession:

> Without the [new college] I think we continue to see that bell curve slide down that mechanistic, medicalistic view, and I think eventually that will mean that there's no chiropractic, there's a technique called chiropractic which is manipulation. … The other [possible future] is with the [new college] and with the [new college] I think the worst-case scenario is that things stay as they currently are. We hold a ground, we produce chiropractors that think vitalistically and have practices that way.

These different scenarios touch on another key struggle occurring within the field, which is the question over chiropractic's relationship to medicine and other manual therapies.

4.3. Constructing professional identity

Chiropractic's relationship to medicine has historically been fraught (Dew, 2000; Willis, 1983). Although in Australia and the UK chiropractic has the same regulatory status as the medical profession, it remains largely excluded from the public healthcare system, with general practitioners (GPs) typically the gatekeepers to what limited public access patients have to chiropractic. After the Australian media covered a range of chiropractic 'scandals' in 2015 and 2016, including the discovery of a YouTube clip of a chiropractor adjusting a newborn, the Royal Australian College of General Practitioners encouraged GPs to 'seriously reconsider any support for chiropractic involvement in patient care' (Cavazzini, 2016).

Chiropractor 1 (Australia) believed the media coverage had polarised the chiropractic profession between those wanting to 'hit back' at medicine and those who thought the best approach was to 'get their own house in order'. Through these debates, boundaries were constructed around chiropractic's professional identity. Saks (1996) has traced the historical shift from labelling CAM modalities 'quackery', to being renamed 'complementary medicine' in the late twentieth century as acceptance grew. In my study, chiropractic academics pushed this one step further, invoking a linear and aspirational trajectory from having been 'alternative', to being 'complementary', to becoming part of 'allied health'. When recruiting participants - using an information sheet that mentioned 'CAM' - and during the interviews, it became clear that many wished to drop the profession's alternative associations:

> It's probably a good time to say I actually don't see this profession as CAM, I see us more as allied health. (Chiropractic Academic 4, Australia)
>
> We don't like the term alternative. Complementary - but even that is almost - we see ourselves hopefully eventually quite firmly established within, you know, orthodox healthcare and management of musculoskeletal conditions conservatively. (Chiropractic Academic 14, UK)

Aspiring to be included in allied health implies aligning with, rather than diverging from, mainstream medicine and the other allied health professions. Physiotherapy is the main manual allied health therapy and a profession that has also had a tense relationship with chiropractic (O'Neill, 1994; Norris, 2001). Chiropractors whose habitus positioned them towards the musculoskeletally-oriented, heteronomous pole of the field, tended to downplay the inter-professional differences:

> CB: So do you consider chiropractic to be complementary, allied or alternative medicine, or none of those things?
>
> Chiropractic Academic 1 (Australia): All of those words but allied, I guess, would be closest. I certainly wouldn't say alternative, because alternative to what? … I would say allied health I think. We can certainly work alongside or with mainstream medicine, the same way physiotherapy does. I really don't see much difference between the professions to be honest. … If you went to a musculoskeletal physiotherapist, I don't think there would be an awful lot of difference between what we really do, apart from slight technique differences.

In these comments, the boundaries drawn are between chiropractic and 'alternative' therapies, and not between chiropractic and physiotherapy. This contrasts with boundary-work observed among musculoskeletal practitioners in earlier research (Norris, 2001) and was another area where the differences were particularly marked between the traditional and research-oriented chiropractors. More traditional chiropractors regularly named physiotherapy as the very profession they wanted to distinguish themselves from. This was another motive for establishing a private chiropractic college: 'they come out [of university] not being able to know how they're different to a physiotherapist' (Chiropractor 7). Chiropractor 6 was frustrated by what he perceived as efforts within some sectors of the profession to eschew chiropractic's esoteric knowledge in favour of a limited musculoskeletal focus:

> It's a political push by another group hoping to kowtow to political medicine for recognition and legitimisation and are ready to probably wipe out a number of aspects of scope of practice in an attempt to become recognised as musculoskeletal — for simple musculoskeletal, simple backache, not children, not oldies, not this, not that, and, [*sarcastically*] 'Is that enough now?

Are you happy, or do you want me not to do anything else?' and one year, then, 'Why not, I probably should just become a physio'.

Bourdieu notes that agents are usually most dismissive of those in the field who are their closest competitors (Bourdieu and Wacquant, 1992:100). Within the healthcare field, chiropractic and physiotherapy compete for patients with similar conditions, with physiotherapy being a much larger profession fully integrated into the public health system - privileges denied to chiropractic (Norris, 2001). The divergent strategies being adopted within the chiropractic field – on one side, maintaining professional distinctions, on the other, reducing them – illustrates again the gulf between the two poles of the field. The academic chiropractors' perception of physiotherapy as an ally, rather than a competitor, suggests their increasing orientation towards the broader field of healthcare, and consequent increased heteronomy of the chiropractic field.

5. Conclusion

This paper has shed light on the ongoing and varied professionalisation strategies at play within the chiropractic field in Australia and the UK. It demonstrates that such strategies are implemented even after formal professional status has been achieved. The differing approaches at the two poles of the chiropractic field also reveal the diverse range of professionalisation strategies possible. While differentiation from other professions has been thought important in the past, this study showed that the musculoskeletal, academically oriented sector is attempting to become more like mainstream allied health professions, including physiotherapy. University education is typically seen as a goal of aspiring professions, yet some at the vitalistic pole of chiropractic are attempting to return to small private colleges. Boundary-work between these two groups occurred both formally (such as via exclusion of vitalistic practitioners from professional associations) and informally (such as via the provision of unofficial lessons in chiropractic philosophy, undermining the universities' stance).

These findings show that professionalisation strategies are dependent on context and on the dispositions of specific agents enacting them. Supporting Bourdieu's view of professions, chiropractors comprise a diverse group of individuals positioned differently across a field in which capital, strategies and the future of the profession are competed over. Bourdieu's theory of the autonomy-heteronomy tension within fields is particularly pertinent to the dynamics uncovered in this study. The vitalistic chiropractors tended to be oriented towards autonomy: their values and strategies came from within the professional field (e.g. preserving chiropractic philosophy) and they aimed to maintain the boundaries between themselves and outsiders. The musculoskeletal chiropractors were more heteronomously oriented: they looked to other fields and professions to determine their values (e.g. seeking to build an evidence base accepted within mainstream health) and desired to break down inter-professional boundaries.

Both sets of strategies were rewarded with capital in some form or another, although there is some evidence that the validation of academic forms of capital (research and evidence) was being taken up at the vitalistic pole of the field, suggesting a shift in the field's doxa and the growing dominance of the musculoskeletal paradigm. Certainly it cannot be said that subluxation continues to unite the profession, given its outright rejection by some academics. However, although the academic doxa might be gaining ground, the vitalistic chiropractors are not necessarily being 'silenced' as Villanueva-Russell (2011) contends from her document analysis. The study uncovered the various ways in which vitalistic chiropractors resist being silenced, including establishing alternative education channels. Hence, this is not simply a case of restratification within a profession, but rather a struggle over the very definition of the profession and its boundaries. As long as such a struggle continues, those involved in it can be seen as constituting a Bourdieusian field (Bourdieu and Wacquant, 1992:100–101).

The study's limitations include the relatively small number of chiropractic participants from outside universities and the focus on two quite similar countries, beyond which findings cannot be generalised. Future research might attempt to map the international dimensions of the chiropractic field, of which the UK and Australia can be seen as a subset. Participants often contrasted the flavour of chiropractic in North America (more vitalistic) and Europe (more musculoskeletal), and how such trends shape the global chiropractic field is important for understanding the profession's prospects.

Based on this study, a number of chiropractic futures seem possible, as identified by the participants themselves. All asserted that public demand for chiropractic has not waned, hence deprofessionalisation seems unlikely (Nancarrow and Borthwick, 2005:914). One future would see a split in the profession, with musculoskeletal chiropractic breaking away to become integrated into mainstream healthcare, perhaps even merging with other manual therapies to form a generalised musculoskeletal profession (notably, some osteopath interviewees also envisioned this shared future). Vitalistic chiropractic might then re-establish itself as a separate alternative modality, perhaps beginning another independent phase of professionalisation, or, as one participant suggested, surviving on the margins as a 'niche' therapy. Another possibility is that the profession will survive in its existing form, retaining a distinctive identity but not fully accepted in mainstream health care. What is clear is that the strategies that are currently being deployed to propel the profession are pulling it in different directions.

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